

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035789  
STATE FILE NUMBER

FILED OCT 31 1958

Registration District No. 71 Primary Registration District No. 5012 Registrar's No. 77

300  
1-57  
0

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>EXCELSIOR SPRINGS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>EX. SPRS. HOSP.</u>	Length of stay in 1b <u>2 1/2 YRS.</u>	d. STREET ADDRESS <u>206 W. EXCELSIOR</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>DIETZ</u> Last <u>DIETZ</u>	4. DATE OF DEATH Month <u>OCT.</u> Day <u>8</u> Year <u>1958</u>
--	---

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1882</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
-----------------------	----------------------------------	---	--------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>CARLINVILLE, ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>CONRAD DIETZ</u>	13b. MOTHER'S MAIDEN NAME <u>CATHERINE HOUSE</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>520-24-7138A</u>	17. INFORMANT <u>MRS. FRANK BELLEM, ILLINOIS</u>	Address: <u>CARLINVILLE, ILLINOIS</u>
---	--	---	---------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>	
DUE TO (c) <u>332 X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Transurethral Prostatectomy 3 wks ago</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>EXCELSIOR SPRINGS, MO.</u>	COUNTY <u>CLAY</u>	STATE <u>MO.</u>
---	--	--	---	-----------------------	---------------------

21. I attended the deceased from <u>9-28-58</u> to <u>10-8-58</u> and last saw him alive on <u>10-8-58</u> Death occurred at <u>1:15 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>George E. Sanders M.D.</u>	22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>10-9-58</u>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-10-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>	23d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO.</u>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>	ADDRESS <u>Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>10-12-58</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>
--	---	---	--

Excelsior Springs, Missouri Embellisher's Statement on Reverse Side

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Lowell Jarman* .....

Licensed Embalmer No. *4589* .....  
P. O. Address *Excelsior Springs, Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.