

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016272  
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 209

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Mo.</b> b. COUNTY <b>Jefferson Co.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fenton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fenton</b> <i>05 a.o.</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR 4 INSTITUTION <b>Fieser Nursing Home-1 Mo.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Rt 2 Box 228</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>V.</b> Last <b>DIEHL</b>			4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/1872</b>	9. AGE (In years birthday) <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Rock Creek-Jefferson Co.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	---	---	---

13a. FATHER'S NAME <b>Jacob Diehl</b>	13b. MOTHER'S MAIDEN NAME <b>Sophia Hogg</b>	14. NAME OF HUSBAND OR WIFE <b>Mary T. Diehl</b>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Jacob J. Diehl</b> Address <b>Fenton Mo.</b>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Hypertension C.V. Disease</b> DUE TO (c) <b>Cerebral Hemorrhage</b> CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Cerebral Vascular Accident - Hemiplegia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b> <b>7 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suppurative Parotiditis. 1 week duration.</b>		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.) <b>4201</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 <b>Fenton</b>		COUNTY <b>Jefferson</b> STATE <b>MO.</b>

21. I attended the deceased from **1950** to **25 April 1959** and last saw him alive on **18 April 1959**  
Death occurred at **10:40 AM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Leon H. Lischer D.O.</b>	22b. ADDRESS <b>645 GRAVOIS BOX 215 FENTON, MO.</b>	22c. DATE SIGNED <b>4/27/59.</b>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/28/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fenton MO.</b>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <b>Leon H. Lischer - Fenton Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-2-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
---	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

*Gerald J. Mahru*

Licensed Embalmer No. 4975

P. O. Address De Soto, 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.