

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 21 1959

'59 0 4 6 1 4 9

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3342

EMENDED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton 5		Length of stay in 1b 82 Yrs.		c. CITY OR TOWN Clayton 5,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7514 Byron Place			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7514 Byron Place		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN (NMN) DIECKRIEDE				4. DATE OF DEATH Month Day Year December 14, 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/10/1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner				10b. KIND OF BUSINESS OR INDUSTRY Wulfring-Dieckriede Grocery Co.		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Charles B. Dieckriede			13b. MOTHER'S MAIDEN NAME Emma Mincke			14. NAME OF HUSBAND OR WIFE Alice Stecker Dieckriede			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-09-3423		17. INFORMANT Address Mrs. Edwin Dieckriede 7514 Byron Pl.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchus pneumoniae							INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart Disease							years		
DUE TO (c) General arteriosclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Multiple small cerebrovascular thromboses						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 a.m. p.m.		Month, Day, Year							
20d. INJURY OCCURRED 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		COUNTY		STATE	
21. I attended the deceased from 12-13-59 to 12-14-59 and last saw him alive on 12-13-59 Death occurred at 6:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) Keith S. Wilcox, M.D.		22b. ADDRESS 4952 Maryland Ave.		22c. DATE SIGNED 12/14/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/16/1959	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.		23d. LOCATION (City, town, or county) St. Louis, Missouri		23e. (State)			
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, Inc. 6175 Delmar			25. DATE RECD. BY LOCAL REG. 12-15-59		26. REGISTRAR'S SIGNATURE John B. [Signature]				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Keith Wilson
4952 Maryland Ave.
FO. 1 2910
1 to 5 PM
31'

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joseph E. McCulloch

Licensed Embalmer No. 2764

P. O. Address 6125 2nd St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.