

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012502

FILED VS MAR 24 1960

2 2829

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>JEFFERSON</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>DE SOTO, 0500 2</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>CARDINAL GLENON HOSP</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>Route #2</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARSHA</i> Middle <i>ANN</i> Last <i>Dierks</i>				4. DATE OF DEATH Month <i>MAR</i> Day <i>10</i> Year <i>1960</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>3-7-60</i>	9. AGE (last birthday) <i>—</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>—</i>	IF UNDER 24 HR Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (City and state or country) <i>DE SOTO, MO</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>RAYMOND DIERKS</i>			13b. MOTHER'S MAIDEN NAME <i>LORETTA VALLE</i>			14. NAME OF HUSBAND OR WIFE <i>None</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>RAYMOND DIERKS R2 De Soto, Mo</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO (b) <i>Renatal atelectasis / Prematurity</i> DUE TO (c) <i>762.5</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <i>—</i> Month, Day, Year <i>—</i>								
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		COUNTY STATE		
21. I attended the deceased from <i>March 7</i> to <i>March 9</i> and last saw her <i>him</i> alive on <i>March 9</i> Death occurred at <i>3-10-60 @ 4:20 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Maceola L. Cole, M.D.</i>				22b. ADDRESS <i>Cardinal Glenn Hospital</i>		22c. DATE SIGNED <i>3/10/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3/10/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>De Soto, Mo</i>				
24. FUNERAL DIRECTOR <i>MAHN Funeral Home</i>			ADDRESS <i>De Soto, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 11 1960</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Serald J. Mahu

Licensed Embalmer No. 4975

P. O. Address Dr Soto, 8

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.