

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024446

FILED VS JUN 27 1960

318

1003

6090

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 Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 40 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2744 Osage Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle JOHN Last DIETERICH			4. DATE OF DEATH Month June Day 13 Year 1960					
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 9/25/1911	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat cutter			10b. KIND OF BUSINESS OR INDUSTRY retail meat market		11. BIRTHPLACE (City and state or country) Ashley, Illinois		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Andrew Dieterich			13b. MOTHER'S MAIDEN NAME Anthna Green		14. NAME OF HUSBAND OR WIFE Bernice Falter			
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. 492-05-9718	17. INFORMANT Address Mrs. Bernice Dieterich, 2744 Osage St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO-RENAL SYNDROME							INTERVAL BETWEEN ONSET AND DEATH 4 DAYS.	
DUE TO (b) CARDIAC-CIRRHOSIS 410X							6 MONS.	
DUE TO (c) RHEUMATIC VALVULAR HEART WITH STENOSIS							20 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC PULMONARY ARTERIES							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 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 _____ a.m. _____ p.m. Month, Day, Year _____								
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 2-23-50 to 6-13-60 and last saw him alive on 6-13-60 Death occurred at 10:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Henry Cooper M.D.				22b. ADDRESS 818 Olive St.			22c. DATE SIGNED 6/14/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE June 16, 1960	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.			25. DATE RECD. BY LOCAL REG. JUN 14 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Henry T. Cooper
Paul Brown Bldg.
to 3 PM

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 Horner H. Dwyer

Licensed Embalmer No. 388

P. O. Address St. Louis

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.