# SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=010676
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3021

FILED APR 14 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Our Lady of Perpetual Help Nursing Home
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4648a Michigan Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: EMILIE Middle: R. Last: DIERKES
4. DATE OF DEATH: Month: March Day: 28 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12-13-1890
9. AGE (last birthday): 70
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Ferdinand Luithardt
13b. MOTHER'S MAIDEN NAME: Louisa Schmid
14. NAME OF HUSBAND OR WIFE: Late John B. Dierkes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Margaret Gailus Address: 4027 Connecticut St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: ½ hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Amyotrophic lateral sclerosis — 3 yrs.??
DUE TO (c) 356.1
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct. 1, 1959, to Mar. 28, 1961 and last saw her/him alive on Mar. 27, 1961
Death occurred at 10:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible], MD
22b. ADDRESS: 4145 a S. Grand Blvd.
22c. DATE SIGNED: 3.29.61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Apr. 3, 1961
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: MAR 30 1961
26. REGISTRAR'S SIGNATURE: [illegible] Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

## 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 _____

Licensed Embalmer No. 4533

P. O. Address _____

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.