MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-010680
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2781

FILED MAR 30 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: MISSOURI BAPTIST HOSP. Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST LOUIS, Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 4007 NO. TAYLOR AVE Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First ANNA Middle MARGARET Last DINEEN
4. DATE OF DEATH: Month MARCH Day 22 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married X Widowed ☐ Divorced ☐
8. DATE OF BIRTH: ABOUT 1892
9. AGE (last birthday): ABOUT 69
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): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): ST LOUIS MISSOURI
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: PETER DINEEN
13b. MOTHER'S MAIDEN NAME: MARY GAEPFERT
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JAMES SHELVY Address: 4307 OAKRIDGE AVE

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): adeno carcinoma hepatic — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): adenocarcinoma of colon — 2 yrs
DUE TO (c): acute cardiac failure
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 153.8
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 1950 to 3-22-61 and last saw her/him alive on 3-21-60
Death occurred at 8:30 am 8:30 A 8a m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE J. A. Seabold (Degree or title) M.D.
22b. ADDRESS Carleton Bldg.
22c. DATE SIGNED 3-23
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 3/24/61
23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEMETERY
23d. LOCATION (City, town, or county) (State): ST LOUIS MISSOURI
24. FUNERAL DIRECTOR: STROOT – CARROLL ADDRESS: 4600 NAT'L BRIDGE
25. DATE RECD. BY LOCAL REG.: MAR 23 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

Dr Leabold
Carlton Bldg
Ia 10070 12 to 2 Thurs

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 M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis, M

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.