

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043119

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3242

STATE FILE NUMBER

FILED DEC 11 1961

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>		Length of stay in 1b <u>86 days</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4059 Westminster</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>G.</u> Last <u>Diehl</u>			4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>61</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>69</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME <u>Victor Diehl</u>		11b. MOTHER'S MAIDEN NAME <u>Unknown</u>	11. BIRTHPLACE (City and state or country) <u>Sullivan, Mo.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. 17. INFORMANT Address <u>Records of Robert Koch Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute recurrent cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Generalized arteriosclerosis</u>			
DUE TO (c) <u>Arteriosclerotic heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral arteriosclerosis, Expressive aphasia</u>			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 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 <u>8-18-61</u> to <u>11-12-61</u> and last saw <u>him</u> alive on <u>11-12-61</u> . Death occurred at <u>3</u> <u>a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Howard J. Russell M.D.</u>		22b. ADDRESS <u>Robert Koch Hospital Koch, Mo.</u>	22c. DATE SIGNED <u>11-13-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-17-61</u>	23c. NAME OF CEMETERY, OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>11-15-61</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>

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 Malvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Wash

St. Louis, Mo

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.