

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-003667

STATE FILE NUMBER

318

1003

72

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b <b>84 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Geitner Home, 5000 So. Brdwy</b>		d. STREET ADDRESS (If outside, give location) <b>4157 Magnolia Ave.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Margaret</b> Last <b>Dinges</b>	4. DATE OF DEATH Month <b>Jan</b> Day <b>1</b> Year <b>1962</b>
--	--

5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/1877</b>	9. AGE (last birthday) <b>84</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	--	--	---

13a. FATHER'S NAME <b>Henry Christian Krull</b>	13b. MOTHER'S MAIDEN NAME <b>Helene Seidler</b>	14. NAME OF HUSBAND OR WIFE <b>George Michael Dinges</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Helen A. Dinges 1910 Pennsylvania Ave. East Warren, Penn.</b>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 years</b> <b>4 years</b>
---	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute respiratory infection 420.0</b>	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 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 a.m. p.m.
---

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 1960 to 12/28/61 and last saw her/him alive on 12/28/61  
Death occurred at 2:05 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>W. P. Krowlton MD</b>	22b. ADDRESS <b>3720 Washington Blvd St Louis 8 Mo.</b>	22c. DATE SIGNED <b>1/2/62</b>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal rail</b>	23b. DATE <b>1/4/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Warren, Pennsylvania</b>
--	------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons, 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 3 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
--	---	--

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Norman P. Knowlton, Jr.

3720 Washington Ave.

Phone OL 2- 4935

**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 Joe E. McEwen

Licensed Embalmer No. 2460

P. O. Address 617 W. 1st St. S. Duluth, Minn.

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.