

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014135

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 961

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 11 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 <u>4002</u>	
2 <u>40122</u>	
3	
4 <u>0</u>	
5 <u>1</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>421.1</u>	
10	
11	
12 <u>92-0</u>	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Crestwood</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>833 Sanders Dr.</u>
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>C.</u> Last <u>DINNIUS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-St. Louis Public Service Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>64</u>
11a. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John J. Dinnius</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Wester</u>	
14. NAME OF HUSBAND OR WIFE <u>Helen A. Dinnius</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Helen A. Dinnius 833 Sanders Dr.</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>CARDIAC DECOMPENSATION</u> DUE TO (b) <u>AORTIC INSUFFICIENCY</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>
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. <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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>April 1962</u> to <u>3-17-63</u> and last saw her alive on <u>3-1-63</u> . Death occurred at <u>11:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Emm M. Schenhardt M.D.</u>		22b. ADDRESS <u>3903 Park Ave. St. Louis</u>	
22c. DATE SIGNED <u>3-19-63</u>		23. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Mar. 20, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S/S Peter & Paul Cem.</u>	
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>3-19-63</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Erwin Leonhardt
#18 S. Kingshighway Blvd.
12-4 Tue.

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 James R. Quinn

Licensed Embalmer No. 4527

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.