N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 14 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32399
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 8453
(c) City St. Louis (d) Street No. City Infirmary St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 71 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henry Ettman
(a) Residence, No. City Infirmary St. 13
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk.
7. AGE: About 71 YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

FATHER
13. NAME Adolph Ettman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER
15. MAIDEN NAME Louise Levi
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

17. INFORMANT (ADDRESS) Myer Stein 5793 Westminster
18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Mt Olive Cem DATE Sept. 8 1937
19. FUNERAL DIRECTOR (ADDRESS) Herman Rondskopf 5216 Delmar Blvd
20. FILED SEP 8 1937 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH
No Physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sep. 7, 1937. 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 1:45 A.M.
The principal cause of death and related causes of importance were as follows:

Chronic Fibrous Myocarditis; old infarction of left ventricle wall with calcification.

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury See above

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Joseph M. Quinn, M.D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

Howard F Rowland, Licensed Embalmer No. 3114

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Howard F Rowland

Licensed Embalmer No. 3114

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)