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23159

FILED OCT 18 1941

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether _____)
In this community **25 years**
(years, months or days)

3. (a) PRINT FULL NAME **Mrs. Louise P. Dietrich**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Widowed**

6. (b) Name of husband or wife **Ferdinand Dietrich** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 27, 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 **2** **2** _____ hr. _____ min.

9. Birthplace **Shawneetown, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Household**

11. Industry or business

12. Name **Conrad Scholl**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Koessel**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Scholl**

(b) Address **3141 Chippewa**

17. (a) **Burial** (b) Date thereof **Sept. 1, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Beiderwieden F. H. Inc.**

(b) Address **1936 St. Louis Avenue**

19. **SEP 1 1941** (Date received local registrar) (b) **J. B. Beck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **24** **17**
(If outside city or town limits, write "RURAL") **9**
(d) Street No. **3535 South 2nd, Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **29th**
year **1941** hour **8** minute **27** P. M.

21. I hereby certify that I attended the deceased from **August 25**, 19**41**, to **August 29**, 19**41**.

that I last saw her alive on **August 29**, 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**
Auricular Flutter

Due to **Hypertension** **5 days**
Myocarditis, Chronic **8 days**
Due to **Chronic Nephritis** **1 year**

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations **131**
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Heroy E. Ellison, M.D.** (M. D. or other)
Address **3616 So Broadway** Date signed **8-30-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Leroy E. Ellis
3616 Broadway

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Julius J. Krupin

Licensed Embalmer No. 3497

P. O. Address 1936 St Louis

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

If this body is not embalmed, fact should be so stated above.