

FILED JUN 18 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 4713

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:  
Home for the Aged, 3400 So. Grand.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 Years.  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County 000 17 16  
 (c) City or town St. Louis, 9  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3400 So. Grand.,  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME William Dittmer,

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

4. Sex Male, 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed,  
 6. (b) Name of husband or wife Anna Schulz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased November 15, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 6 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Dittmer,  
 { 13. Birthplace Don't Know, 9  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name Helen Wilker,  
 { 15. Birthplace Don't Know, 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Bernadette,  
 (b) Address 3400 So. Grand.

17. (a) Burial, (b) Date thereof 5/23/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul Cem.

18. (a) Signature of funeral director Gebken-Benz Mortuary,

(b) Address 2842 Meramec St.,

19. (a) MAY 22 1944 (Date received local registrar) J. F. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st  
 year 1944 hour 3:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from 6 May 21 to 19 1944  
 that I last saw him alive on May 19 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Cerebral Haemorrhage  
Entered Sclerosis 2 yrs

Due to Ch of hypertens 1 yr

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations 13!  
 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? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
 Address Area 100 B 7 Date signed 5/23

**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*Joe D. Benz*  
Licensed Embalmer No. 4249  
2842 Meramec St.,  
P. O. Address St. Louis, Mo.

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 319Primary Registration District No. 1003Registrar's No. 4713

## 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:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution..... (Specify whether

In this community.....  
years, months or days)3. (a) PRINT FULL NAME Wm. Bennett

3. (b) If veteran,
- 
- name war.....

3. (c) Social Security
- 
- No.....

4. Sex
- M
5. Color or race
- W
6. (a) Single, widowed, married,
- 
- divorced
- W

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
- 
- alive..... years

7. Birth date of deceased
- Nov
- 14
- 1942
- 
- (Month) (Day) (Year)

8. AGE: Years
- 27
- Months
- 6
- Days
- 10
- In less than one day..... min.

9. Birthplace.....
- 
- (City, town, or county) (State or foreign country)

10. Usual occupation
- General farmer

## 11. Industry or business

12. Name.....

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

14. Maiden name.....

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

## 16. (a) Informant

(b) Address.....

17. (a)..... (b) Date thereof.....
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)
- 11/16 1944
- (b)
- J. F. Brudak
- 
- (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....

- (c) City or town.....
- 
- (If outside city or town limits, write "RURAL")

- (d) Street No.....
- 
- (If rural, give location)

- (e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- March
- day.....
- 
- year
- 1944
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;

that I last saw him..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

## Major findings:

Of operations.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

10291