

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1707**
Registrar's No. **78**

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **one day**
(Specify whether
In this community **Lifetime**
years, months or days)

3. (a) PRINT FULL NAME **William A. Dittmore**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ida Belle** 6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **March 26, 1891**
(Month) (Day) (Year)

8. AGE: Years **53** Months **9** Days **25** If less than one day
hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business **Farm**

12. Name **James E. Dittmore**

13. Birthplace **Buchanan Co., Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary E. Lux**

15. Birthplace **Buchanan Co., Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ida Belle Dittmore (Wife)**

(b) Address **Rt. # 2, Halls, Missouri**

17. (a) **Burial** (b) Date thereof **1/24/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Cemetery**

18. (a) Signature of funeral director **John E. Dittmore**

(b) Address **6054 Pryor Ave., City**

19. (a) **1-24-45** (b) **John E. Dittmore**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **Halls, (Rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. # 2**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **21**,
year **1945** hour **2** minute **30 P.M.**

21. I hereby certify that I attended the deceased from
1-20-45 to **1-21-45**
that I last saw him alive on **1-21-45**
and that death occurred on the date and hour stated above.

Immediate cause of death
**isolated heart-
apoplexy-
respiratory coma-
nefroretic**
Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) (a) Means of injury

23. Signature **W. B. Smicous** (M. D. or other)

Address **Joseph Mo** Date signed **1/23/45**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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, ~~on~~.....

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

Signed.....

John E. Rupp

Licensed Embalmer No. *8986*.....

P. O. Address *St. Joseph, Mo.*

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