#34861

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11154

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3445

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 MO-4 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 7 H + Lafayette Ave.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME HENRY DITTMAR

3. (b) If veteran, name war

3. (c) Social Security No. 497-18-8958

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased May 3, 1880 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	11	13	hr. min.

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

10. Usual occupation BARTENDER

11. Industry or business

FATHER 12. Name Henry Dittmar

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

MOTHER 14. Maiden name Mary Scheid

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

16. (a) Informant Lena Heibeck

(b) Address 2653 Nebraska Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/45 (Month) (Day) (Year)

(c) Place: burial or cremation New St Marcus

18. (a) Signature of funeral director Stoddites & Son

(b) Address 2906 Gravois Ave

19. (a) APR 17 1945 (Date received local registrar) J. F. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th year 1945 hour 5:51 minute A. M.

21. I hereby certify that I attended the deceased from 10/12/44, 19..., to 4/16/45, 19...; that I last saw him alive on 4/16/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cirrhosis of Liver	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy Same

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James [illegible] (M.D. or other)

Address 1515 Lafayette 4/16/45 Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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 David Van Fossan.

Licensed Embalmer No. 4242

P. O. Address 2906 Gravois.

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.

S. No. 2B
-3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11154

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7415

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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Henry Dittmar
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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased May 3 1881 (Month) (Day) (Year)
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) JUL 11 1945 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 16 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY