

S. No. 2
OM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35060**

FILED NOV 12 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9421**

1. PLACE OF DEATH:

(a) County St Louis mo

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

(c) Name of hospital or institution:
City Hosp #1 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Louis

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

(d) Street No. 5630 Pershing
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ALICE CECILE DORRITZER

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 single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased Nov 17 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1946 hour 5 minute 25 A.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.

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>10</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death Hypostatic Pneumonia
Malnutrition

Due to _____

Due to _____

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

Major findings: _____
Of operations: _____

Of autopsy: _____

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

10. Usual occupation none

11. Industry or business none Charles

12. Name Alice Cecile Dorritzer

13. Birthplace St Louis mo Vienna Austria
(City, town, or county) (State or foreign country)

14. Maiden name Tekla Corputer Braden
Alice Cecile Dorritzer

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Kathryn Kueh Gilbert

(b) Address 1507 W. Barry Ave Chicago Ill

17. (a) Anatomical (Burial, cremation, or removal) Date thereof 10/1/46
(Month) (Day) (Year)

(c) Place: burial or cremation St Louis

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

(b) Address _____

19. (a) NOV 4 1946 (Date received local registrar)

(b) [Signature] (Signature of Registrar)

(c) [Signature] (Signature of Registrar)

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

(a) Accident, suicide, or homicide (specify) _____

Date of occurrence _____

(b) Where did injury occur? _____ (City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____

While at work _____ (Specify type of place)

(d) Means of injury 3

Signature [Signature] (M. D. or other) _____

Address [Signature] Date signed 10/11/46

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

35060

99

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.