S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 19 1947

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

30873
State File No.

Registration District No. 118 — Primary Registration District No. 5440 — Registrar's No. 63

**1. PLACE OF DEATH:**

(a) County Gasconade
(b) City or town Rural Clay Twp.
(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 Lifetime

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Gasconade
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Bland Route 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jacob Henry Dittman

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 Rose Strack

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

7. Birth date of deceased January (Month) 26, (Day) 1865 (Year)

8. AGE: Years 82 | Months 7 | Days 3 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER

12. Name John Dittman

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

14. Maiden name Barbara Rupp

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

16. (a) Informant Anna Dittman

(b) Address Bland, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 1 - 47 (Month) (Day) (Year)

(c) Place: burial or cremation Howard Cem. Canaan, Mo.

18. (a) Signature of funeral director Milford H. H. Winter

(b) Address Owensville, Mo.

19. (a) Sep 19 1947 (Date received local registrar) Dorothy Jackson (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 29
year 1947 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from Feb. 3 47 to Aug. 29 1947; that I last saw him alive on Aug. 29 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis With Terminal Decompensation — Duration 6 mos.

Due to .....

Due to .....

Other conditions Benign Prostatic Hypertrophy — Duration 1 yr.
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

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 Paul A. Brenner (M. D. or other) MD

Address Owensville, Mo. Date signed 9-3-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 18 1947

## 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.....
Harvey Hahle, Registered Apprentice No. 9
working under my personal supervision.

Signed Mefford H Winter
Licensed Embalmer No. 3838
P. O. Address Owensville Ind.

**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.**