. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947

Registration District No. 348

# MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 35664

Primary Registration District No. 1003

Registrar's No. 9361

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Firmin Desloge Hosp
(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: Missouri (b) County: Dad
(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 4509 San Francisco 9
(If rural, give location)
(e) Citizen of foreign country? ..... (~~Yes~~ or No) No
If yes, name country .....

3. (a) PRINT FULL NAME: Ditmeyer, Helen
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Albert
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: Dec (Month) 27 (Day) 1882 (Year)

8. AGE: Years 64 Months 9 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace: Carlyle (City, town, or county) Ill. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Self
MOTHER FATHER
12. Name: Jacob Berger
13. Birthplace: Germany (City, town, or county) (State or foreign country)
14. Maiden name: Louise Kiel
15. Birthplace: Ill. (City, town, or county) (State or foreign country)
16. (a) Informant: Albert Ditmeyer
(b) Address: 4509 San Francisco
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/12/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary
18. (a) Signature of funeral director: Provaat Und Co
(b) Address: 3710 N. Grand
19. (a) OCT 9 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8th
year 1947 hour 10 minute 15 A.M.
21. I hereby certify that I attended the deceased from Oct 4th 1947 to Oct 8th 1947
that I last saw her alive on Oct 8th 1947
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral thrombosis | 48 hr. |
| Due to: Cerebral and generalized arteriosclerosis uncertain | |
| ~~Due to~~: 1) Diabetes mellitus | 10 yr |
| 2) Massive retinal detachment bilateral | 3 yr |
| Other conditions (Include pregnancy within 3 months of death): 3) Posterior myocardial infarction | 9 days |

Major findings: Of operations: none
Of autopsy: none

PHYSICIAN
Underline the cause of 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: Robert E. Fox (M. D. or other)
Address: 1325 So. Grand Blvd Date signed: 10/8/47

Jefferson City Printing Co.

(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 Albert Mayfield

Licensed Embalmer No. 3077

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.**