

#91656
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 2 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38036
State File No.

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10155

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 - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME CHARLES DILLMAN

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 Single

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 65 hr. min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown

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 Dr. Frank Tracy

(b) Address 2343 Olive St.

17. (a) burial (b) Date thereof 11-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Harrigan & Sheahan

(b) Address 4435 Washington Ave.

19. (a) NOV 23 1948 (b) J. B. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2343 Olive St. - Olivia Apts.
Memorial (If rural, give location)
(e) Citizen of foreign country? 21 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22nd
year 1948 hour 12 minute 00 A. M.

21. I hereby certify that I attended the deceased from 11/10/48
19____ to Nov. 22nd 1948

that I last saw him alive on Nov. 22nd 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis Duration 12 days
Left Middle

Due to Cerebral Artery

Due to Arteriosclerosis

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

Major findings: g
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? _____

While at work? g (Specify type of place) (e) Means of injury M.D.

23. Signature 1515 Lafayette 11/22/48 (Other) _____

Address _____ Date signed _____

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 *Robert M Murray*
Licensed Embalmer No. *3749*
P. O. Address *St. Louis, 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.