

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3350**

FILED JAN 28 1950

4001  
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BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>3064</b>		Registrar's No. <b>179</b>		
1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, write RURAL and give township) <b>Ferguson</b>		c. LENGTH OF STAY (in this place) <b>2 Weeks</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Bel-Nor</b>		418		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Halls Ferry Nursing Home</b>				d. STREET ADDRESS (If rural, give location) <b>3051 Arlmont Drive</b>				
3. NAME OF DECEASED a. (First) <b>Emma</b>		b. (Middle) _____		c. (Last) <b>Witthoff</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 19th, 1950</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Aug. 28th, 1857</b>		
9. AGE (In years last birthday) <b>92</b>		IF UNDER 1 YEAR <b>4</b> Months		IF UNDER 1 YEAR <b>21</b> Days		IF UNDER 1 HRS. _____ Hours _____ Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Saint Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>Eberhard Boeckstiegel</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Late William Witthoff</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Gilbert Witthoff, 3051 Arlmont Drive</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc.* It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>332X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>  <b>5 years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION  <b>332X</b>						
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <b>Jan 10, 1950</b> , to <b>Jan 19, 1950</b> , that I last saw the deceased alive on <b>Jan 16, 1950</b> , and that death occurred at <b>4:00 P. M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Lewis Lettmann MD</b>				23b. ADDRESS <b>8231 Clayton Rd (17)</b>		23c. DATE SIGNED <b>1/20/50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1/21/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Saint Johns Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Saint Louis County, Missouri</b>		
DATE REC'D BY LOCAL <b>JAN 20 1950</b>		REGISTRAR'S SIGNATURE <b>Herbert K. Dowe, MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F. Feutz</b>		ADDRESS <b>4828 Natural Bridge Bl.</b>		

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

Dr. Lewis E. Lettman  
8731 Clayton Road  
PA. 0207  
between 3<sup>00</sup>/<sub>4</sub> 5<sup>00</sup>/<sub>PM</sub>

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*John A. Miller*

Licensed Embalmer No. \_\_\_\_\_

*4186*

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.