

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**58-035134**  
STATE FILE NUMBER  
**8252**

XC1627844  
Reg. #120651  
Registration District No. **317 318** Primary Registration District No. **1003-500** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Mo.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson Barracks</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Edwardsville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Veterans Adm. Hosp</b>		Length of stay in 1b <b>2277 days</b>	d. STREET ADDRESS (If outside, give location) <b>307 W. Park</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>C</b> Last <b>TIETZE</b>			4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-85</b>	9. AGE (In years last birthday) <b>73</b>	10. FUNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Prof.</b>	11. BIRTHPLACE (City and state or country) <b>West Salem, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>William Tietze</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Bauer</b>		14. NAME OF HUSBAND OR WIFE <b>Maude B Tietze</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>VA HOSPITAL RECORDS, JEFFERSON BARRACKS, MO</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>ARTERIOSCLEROSIS with CEREBRAL THROMBOSIS</b>					<b>6 Years</b>
DUE TO (c) <input checked="" type="checkbox"/> <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>					<b>10 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PROSTATIC HYPERTROPHY</b>					<b>3 Years</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>443x</b>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>5-27-52</b> , to <b>8-24-58</b> Death occurred at <b>8-24-58 12:40 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W. Oppler</b> (Degree or title) <b>W. OPPLER, M.D., DIRECTOR PROF. SVCS.</b>			22b. ADDRESS <b>VAH JEFFERSON BARRACKS, MO.</b>		22c. DATE SIGNED <b>8-24-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-25-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moravian Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Edwardsville, Illinois.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b>			ADDRESS <b>4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 25 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, m d</b>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

AT 6-7-90-67

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 .....  
Signature of Student Embalmer

Signed *Stanley H. Dixon* .....

Licensed Embalmer No. *4193* .....

P. O. Address: *St. L.* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.