RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

-60-008132

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2267

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Park Lane Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St.Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4308 McPherson
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Charles Middle: Last: Ditterline
4. DATE OF DEATH: Month: February Day: 25, Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 4/23/1892
9. AGE (last birthday): 67
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Thomas Ditterline
13b. MOTHER'S MAIDEN NAME: Mary Triplett
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Marcella Wicker, 1342 Meridan, Granite City, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension & Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2-21-60 to 2-25-60
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 444
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 2-21-60, to 2-25-60 and last saw ~~her~~ him alive on 2-25-60
Death occurred at 3:15 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Earl J. Smith M.D. (Degree or title)
22b. ADDRESS: 4930 Lindell St. Louis Mo.
22c. DATE SIGNED: 2-26-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-26-60
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Oran, Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 26 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.