

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

State File No. **33133**

No. 300
10.48

FILED OCT 17 1949

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5125 Registrar's No. 1104

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN DeKalb -Center		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN DeKalb, Rural Center Twsp.	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) R.F.D. # 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. # 1, DeKalb, Mo.			

3. NAME OF DECEASED (Type or Print) a. (First) ANNETTA b. (Middle) _____ c. (Last) DITTEMORE			4. DATE OF DEATH (Month) (Day) (Year) 10 10 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 12, 1880	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Clearmore, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Preston Williams	13b. MOTHER'S MAIDEN NAME Lucinda Rowe	14. NAME OF HUSBAND OR WIFE Fred Dittmore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Dittmore, DeKalb, Mo.

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, assthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion Immediate	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Sclerosis 2 years DUE TO (c) _____ 4 1/2 yr	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis 2 years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 1946 19 , to 10-10- 1949 that I last saw the deceased alive on 10-9- 1949 and that death occurred at 2:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Benjamin M. Rees D.O.	23b. ADDRESS St. Joseph, Mo. 2822 E. Bond St.	23c. DATE SIGNED 10-11-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Bethel
		24d. LOCATION (City, town, or county) (State) DeKalb, Missouri

DATE REC'D BY LOCAL REG. Oct. 13, 1949	REGISTRAR'S SIGNATURE E. B. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John E. Rees, St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 E. Rupp
Licensed Embalmer No. 3986

P. O. Address *St. Joseph, 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.