

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

32552

OCT 14 1937

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis, Mo.** (No. .... City Sanitarium St. .... Ward)

File No. ....  
 Registered No. **8606**

**2. FULL NAME** Alice Dietze

(a) Residence, No. 4338 Washington Ave. St., 19 Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

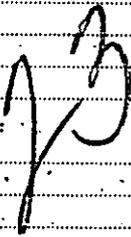
**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>		4. COLOR OR RACE <b>White</b>		5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Single</b>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Single</b>					
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Mar. 8, 1906</b>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.	
	<b>31</b>	<b>6</b>	<b>3</b>		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .... <b>Housework</b>				
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .... <b>Housework</b>				
	10. Date deceased last worked at this occupation (month and year) <b>About 1930</b>				
11. Total time (years) spent in this occupation .....					
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Culin Missouri</b>					
MOTHER FATHER	13. NAME <b>Emil Dietze</b>				
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown Germany</b>				
	15. MAIDEN NAME <b>Amelia Ackerman</b>				
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown Ohio</b>				
17. INFORMANT <u>William T. Paiter, M. D.</u> (ADDRESS) <u>5400 Arshul St</u>					
18. BURIAL-CREATION, OR REMOVAL PLACE <b>Oak Grove</b> DATE <b>Sept. 14, 1937</b>					
19. UNDERTAKER <b>Math. Hermann &amp; Son</b> (ADDRESS) <b>2161 East Fair Avenue</b>					
20. FILED <b>SEP 13 1937</b> <u>J. T. Predeck</u> Registrar.					

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 11/37**, 19

22. I HEREBY CERTIFY, That I attended deceased from **Aug. 14/37**, 19, to **Sept. 11/37**, 19.  
 I last saw her alive on **Sept. 11/37**, 19. Death is said to have occurred on the date stated above, at **2.30 P. M.**  
 The principal cause of death and related causes of importance were as follows:  
**Pulmonary Tuberculosis 8/14/37** Date of onset

Other contributory causes of importance: 

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **NO**  
 If so, specify.....  
 (Signed) William T. Paiter, M. D.  
 (Address) 5400 Arshul St.

STATEMENT BY LICENSED EMBALMER.

I, William G. Buckholz, Licensed Embalmer No. 2110

hereby certify that the body recorded on the reverse side of this certificate  
was embalmed by William G. Buckholz L. E.

No \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No \_\_\_\_\_

working under my personal supervision.

William G. Buckholz

Licensed Embalmer No. 2110