

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

791
1008

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2703 Arsenal St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 72 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 124
(If outside city or town limits, write "RURAL")
 (d) Street No. 2703 Arsenal St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Otto Dietz 320
 8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased August 19th, 1867.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 2 9 hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Plumber

11. Industry or business _____

MOTHER FATHER { 12. Name Not known
 18. Birthplace Not known
(City, town, or county) (State or foreign country)
 14. Maiden name Not known
 15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jewel Liebig
 (b) Address 4991 Fairview

17. (a) burial (b) Date thereof 10/31/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cem.

18. (a) Signature of funeral director John G. Ziegenhain
 (b) Address 7027 Gravois Ave.

19. (a) OCT 30 1939 (b) J. F. Bredack
(Date recorded local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 28
 year 1939 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

 Due to Chronic Myocarditis
 Due to Chronic Phlebotomy
 Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy 93C

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Walter Perry (M. D. or other) 1
 Address 1111 1/2 E. Broadway Date signed 10.30.39

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

MO-5135-50 I 11-1931

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.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *C. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address..... *6937^a Gravois*

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, above space should be left blank.