

NOV FEB 14 1941

Registration District No. 124

Primary Registration District No. 3009

Registrar's No. 40

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU
 (b) City or town " "
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
SOUTHEAST MO. HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 DAYS
 (Specify whether years, months or days)
 In this community 33 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CAPE
 (c) City or town CAPE GIRARDEAU
 (If outside city or town limits, write "RURAL")
 (d) Street No. 501 WASHINGTON AVE.
 (If rural, give location) C 72
 (e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 25
 year 1941 hour 7 minute 15 M.
 21. I hereby certify that I attended the deceased from Jan 16, 1941, to Jan 25, 1941;
 that I last saw her alive on Jan 25/41
 and that death occurred on the date and hour stated above.

Immediate cause of death
Myocarditis Influenza
Pyloric obstruction
 Due to year of lin. infection
Probably carcinoma
 Due to.....
 Due to.....

Duration

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

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?
 While at work (Specify type of place) (e) Means of injury.....

23. Signature Carl M. Zimmerman (M. D. or other) 27
 Address Cape Girardeau Date signed Jan 27

8. (a) PRINT FULL NAME THERESIA DIETRICH
 8. (b) If veteran, name war.....
 8. (c) Social Security No.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife PAUL F. DIETRICH 6. (c) Age of husband 80 years if alive 8-1862
 7. Birth date of deceased NOV 8-1862
 (Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 17
 If less than one day hr. min.

9. Birthplace EBERSA AUSTRIA
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business.....
 12. Name BALTHASER ERLBACHER
 13. Birthplace SDLADMING AUSTRIA
 (City, town, or county) (State or foreign country)
 14. Maiden name E-NEVIEVE KINNINGER
 15. Birthplace AUSTRIA
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edna M. Dietrich
 (b) Address Cape Girardeau, Mo.
 17. (a) BURIAL (b) Date thereof JAN 28-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation MEMORIAL PARK
 18. (a) Signature of funeral director M. G. Larson
 (b) Address Cape Girardeau, Mo.
 19. (a) 1-26-41 (b) Jim Mangrum
 (Date received local registrar) (Registrar's signature)

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.

55

1932
10-12-32
4557

STATE OF ILLINOIS
DEPARTMENT OF HEALTH

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.

C. J. Lorberg

Signed.....

C. J. Lorberg

Licensed Embalmer No. *3810*

P. O. Address. *Cape Girardeau,*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2071

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 120

Primary Registration District No. 3009

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Theresia Dietrich

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 17 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 10/41 to Jan 25 1941

that I last saw her alive on Jan 20/41 and that death occurred on the date and hour stated above.

Immediate cause of death Myo Carditis

5 years obstruction

probably carcinoma

Due to _____

Due to Do not know primary site

Other conditions influenza

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature Carl H. Mann, M.D. (M. D. or other)

Address Cape Girardeau Mo Date signed Apr 19 41

SUPPLEMENTARY

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

MOTHER FATHER

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

Patient whom I first saw had a bronchitis with
some few - marked heart arrhythmia was in evidence
and decompensation eventually took place creating
pulmonary hypertension

No symptoms or signs of disorder of gastro-
intestinal tract became evident until she
had been sick several days. Vomiting attracted
attention to abdomen when gastric peristaltic
waves passed from fundus to pylorus where a
small mass was felt.

It was presumed this was carcinoma but under
the circumstances no extended examination
could be made.

Autopsy not permitted

Respectfully

Carl A. Zimmerman