

FILED JUN 10 1941
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17229
1891
Registrar's No.

Registration District No. 399 Primary Registration District No. 399

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(c) Name of hospital or institution: 229 East 72 St.
(d) Length of stay: In hospital or institution 60 years
In this community 60 years

3. (a) PRINT FULL NAME Anne R. Ditsch
(b) If veteran, name war No
(c) Social Security No. No

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Oscar W. Ditsch
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 14 1863

8. AGE: Years 77 Months 10 Days 29
If less than one day hr. min.

9. Birthplace Herman Mo.

10. Usual occupation At Home

11. Industry or business

12. Name Joseph Kessler
13. Birthplace Germany
14. Maiden name Pauline Pommer
15. Birthplace Penn.

16. (a) Informant Edward W. Burke
(b) Address 229 East 72 St.

17. (a) Burial (b) Date thereof May 15 1941
(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn

19. (a) May 14-41 (b) M M Clowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 229 East 72 St.
(e) If foreign born, how long in U. S. A.?

20. DATE OF DEATH: Month May day 13
year 1941 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec 25 1940 to 5/12 1941
that I last saw her alive on 5/12 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Duration 4 mos

Due to: 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th 13th 14th 15th 16th 17th 18th 19th 20th 21st 22nd 23rd 24th 25th 26th 27th 28th 29th 30th 31st

Other conditions: Ch. myocarditis
Major findings: arteriosclerosis
Of operations: none
Of autopsy: none

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?
(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 J. J. [unclear] (M. D. or other)
Address 907 [unclear] Date signed 5/13/41

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 *me*

....., Registered Apprentice No.
working under my personal supervision.

Signed *L. N. Wise*

Licensed Embalmer No. *25-70*

P. O. Address *Home*

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.