No. 2
1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1941

Registration District No. 784

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 200

State File No. 36161

Registrar's No. 2136

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 30 days
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County —
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5654 Delmar (If rural, give location) E
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Clare Mary Dittoe
3. (b) If veteran, name war —
3. (c) Social Security No. 497-01-0096
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S.D.
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb. (Month) 28 (Day), 1911 (Year)

8. AGE: Years	Months	Days	If less than one day
30	8	22	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Clerical work
11. Industry or business Cosmetic Mfg. Co.
FATHER
12. Name Cornelius J. Dittoe
13. Birthplace Paris (City, town, or county) Ill. (State or foreign country)
MOTHER
14. Maiden name Zilpha Hudson
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Robert Koch Hospital Records.
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date, thereof 10-22-41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Chas. F. Stuart
(b) Address 1285 Union Blvd
19. (a) OCT 21 1941 (Date received local registrar) (b) C. H. McClaran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20 year 1941 hour 12 minute 45 a. M.
21. I hereby certify that I attended the deceased from 6-18-41, 19__ to 10-20-41, 19__; that I last saw her alive on 10-19-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	11 mo.
Due to	
Due to TBM	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature William Stambo (M. D. or other) MD
Address Robert Koch Hospital Date signed 10-20-40

(Licensed Embalmer's Statement on Reverse Side)

NOV 4 1941

MAY 2 1945

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.