

FILED NOV 20 1944

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2318

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Lemay  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
215 W. Arlee Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 12 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Lemay  
(If outside city or town limits, write "RURAL")  
(d) Street No. 215 W. Arlee Avenue  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Peter Dietrich

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rosina Dietrich 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Dec. 12, 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>10</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Peter Dietrich

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

14. Maiden name Catherine Schumacker

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

16. (a) Informant Rosina Dietrich

(b) Address 215 W. Arlee

17. (a) Burial (b) Date thereof Nov. 14, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Fendler Und. Co.

(b) Address 7420 Michigan Avenue

19. (a) NOV 14 1944 (b) E. S. Melaurant  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11  
year 1944 hour 11 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1-20  
1944, to 11-11, 1944

that I last saw h. i. m. alive on 11-11, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Ac. Dilatation of heart  
Duration 1 day

Due to chronic cardio-vascular disease years.

Due to \_\_\_\_\_

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 \_\_\_\_\_

(f) Signature Erwin S. Cukier (M. D. or other) \_\_\_\_\_

Address 748 Lemay, Ferry Rd Date signed 11-11-44

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

7600

**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..... *Albert Mayfield* .....  
Licensed Embalmer No. *3077* .....  
P. O. Address.....

**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.**