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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# FILED APR 29 1946 STANDARD CERTIFICATE OF DEATH

State File No. **14255**

Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **887**

**1. PLACE OF DEATH:**

(a) County St. Louis  
 (b) City or town Clayton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis County Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 28 Hours  
 In this community 9 Months (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis  
 (c) City or town Overland  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 9133a East Milton  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** HENRY CAMMANN  
**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** Widowed  
**6. (b) Name of husband or wife** Elise O'Rourk **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** July 15 1874  
 (Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>71</u>	<u>9</u>	<u>3</u>	hr. _____ min. _____

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

**10. Usual occupation** None

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

**12. Name** Henry J. Cammann

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

**14. Maiden name** Celestine Dittlinger

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

**16. (a) Informant** Patient - self

**(b) Address** as above

**17. (a) Burial** (b) Date thereof April 22 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Sunset Burial Park

**18. (a) Signature of funeral director** Jegerdon Proo

**(b) Address** 6409 Gravois Ave

**19. (a) 4-22-46** (b) Ed M. Savan MD  
 (Date received local registrar) (Registrar's signature)

### MEDICAL CERTIFICATION

**20. DATE OF DEATH:** Month April day 18th  
 year 1946 hour Eight minute 20 P.M.

**21. I hereby certify that I attended the deceased from** April 17th 1946 to April 18th 1946  
 and that death occurred on the date and hour stated above.

that I last saw him alive on April 18th 1946  
 Immediate cause of death Cardiac failure Duration 2 hrs

Due to Left ventricular failure

Due to 302

Other conditions Empyema Rt Pleural cavity  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy as above

### 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** Ed M. Savan MD (M. D. or other) MD

Address St. Louis County Hosp Date signed 4/19/46

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

13155

16  
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JUN 28 1946

MAY 17 1946

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**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 Homer W. Dritz

Licensed Embalmer No. 3882

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.**