

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38650
9485

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3937a Lafayette		d. STREET ADDRESS (If rural, give location) 17 - 3937 A. Lafayette Ave	
3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Dietzler c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 11-2-1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 8-21-1861
9. AGE (In years last birthday) (Specify) 88		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stableman		10b. KIND OF BUSINESS OR INDUSTRY Hydraulic P.B.Co	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Arthur Koehler 9901 Bereick Dr. Affton Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Heart Disease DUE TO (c) none II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right leg missing from middle 10 years of thigh	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? none		22. I hereby certify that I attended the deceased from 1943 , to 11/1 , 19 49 , that I last saw the deceased alive on 11/1 , 19 49 and that death occurred at 12 N from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Proctor C. Hull MD		23b. ADDRESS 3902a Lafayette	
23c. DATE SIGNED 11/2/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 11-4-1949		24c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery	
24d. LOCATION (City, town, or county) (State) 7133 Gravois Ave Mo		DATE RECD BY LOCAL REGISTRY 1949 3	
REGISTRAR'S SIGNATURE J. B. Casater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS See yecken Bur 6409 Gravois Ave	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Henry M. Brammer

Licensed Embalmer No.

4200

P. O. Address

St. Louis

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.