

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029865

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6577**

STATE FILE NUMBER

**FILED AUG 9 1963**

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300 Rev. 4/59  
 1  
 2 **21**  
 3  
 4 **0**  
 5 **1**  
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 13  
**91**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>D O A</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5530 Delmar</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>R</b> Last <b>DI TENHAFFER SR.</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1963</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/22/1894</b>
9. AGE (last birthday) <b>69 years</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Peter Ditenhafer</b>	
13b. MOTHER'S MAIDEN NAME <b>Adelaide Tierney</b>		14. NAME OF HUSBAND OR WIFE <b>Angela Ditenhafer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of serv) <b>No</b>		16. SOCIAL SECURITY NO. <b>871-0-14</b>	
17. INFORMANT <b>Angela Ditenhafer - 5530 Delmar</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbituate poisoning,</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>as result of overdose of prescribed medicine in home on June 23, 1963.</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>as above</b>	
20c. TIME OF INJURY Hour a.m. p.m. <b>6-23-63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>12 Home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	
20g. COUNTY <b>Mo.</b>		20h. STATE <b>Mo.</b>	
21. I attended the deceased from <b>8:00</b> to <b>A.</b> and last saw him alive on <b>8:00</b> A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Helen L Taylor Coroner</b>		22b. ADDRESS <b>1300 Clark Ave</b>	
22c. DATE SIGNED <b>6-24-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>June 26, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR <b>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 24 1963</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>

**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 \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph E. Lindner*

Licensed Embalmer No. 4225

P. O. Address St. Louis Mo.

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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