

FILED JUN 4 1945

Registration District No. 579

Primary Registration District No. 6076

Registrar's No. 1040

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch

(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 704 days
(Specify whether)

In this community Life
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County —

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1511 Cass Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Otto Eugene Wess

3. (b) If veteran, name war none

3. (c) Social Security No. ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1945 hour 7:10 minute A. M.

21. I hereby certify that I attended the deceased from May 14, 1943 to April 28, 1945
that I last saw him alive on April 28, 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 13 1884
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to 130

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>8</u>	<u>15</u>	<u>—</u> hr. <u>—</u> min.

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Leather cutter

11. Industry or business _____

12. Name Charles Wess

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

14. Maiden name Mame Jackson

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

16. (a) Informant Patients Hospital Record

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof May 1 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Mt. Olivet Cem. St. Louis Mo

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 C.

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave. St. Louis Mo

19. (a) MAY 2 1945 (b) E. E. Harrison
(Date received from Registrar) (Registrar's signature)

23. Signature R. Engelman (M. D. or other) _____

Address Robert Koch Hospital Date signed 4/28/45

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 *L.R. Cooper*.....

Licensed Embalmer No. *3633*.....

P. O. Address *2317 Lafayette*.....

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.