

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14899**

FILED MAY 15 1948

Registration District No. **577**

Primary Registration District No. **3069**

Registrar's No. **1089**

1. PLACE OF DEATH:

(a) County **ST LOUIS**  
(b) City or town **ST LOUIS RECREATION CENTER**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **ST MARY'S HOSP. O**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 mo.** (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **MICHAEL W. OTTO**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S O**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **JAN 14 1948**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**3 14** hr. min.

9. Birthplace **ST LOUIS, MO** (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name **WALTER OTTO**  
13. Birthplace **ST. LOUIS MO** (City, town, or county) (State or foreign country)  
14. Maiden name **SHIRLEY DAVIS** (City, town, or county) (State or foreign country)  
15. Birthplace **MO.** (City, town, or county) (State or foreign country)

16. (a) Informant **WALTER OTTO**  
(b) Address **2832 OHIO**

17. (a) **BURIAL** (b) Date thereof **4-30-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **RESURRECTION CEM**

18. (a) Signature of funeral director **Thomas Kulis + son**

(b) Address **2906 GRAVOIS**

19. (a) **4-29-48** (Date entered local registrar) (b) **Paul A. Day MD** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**  
(c) City or town **ST. LOUIS** (If outside city or town limits, write "RURAL")  
(d) Street No. **2832 OHIO** (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28**  
year **1948** hour **1** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **1/14**, 19**48**, to **4/28**, 19**48**;  
that I last saw him alive on **4/28**, 19**48**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, chronic** Duration **3 mo**  
Due to **congenital atonia of bladder** **3 mo**  
Due to \_\_\_\_\_ **137m**  
Other conditions \_\_\_\_\_  
(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?  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature **Ray W Cluff** (M. D. or other) **MD**  
Address **6420 Clayton** Date signed **4/29/48**

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

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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.....

*Leif Budde*

Licensed Embalmer No. *3989*

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