

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 23 1949

State File No. 14470

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6574 Registrar's No. 778

1. PLACE OF DEATH a. COUNTY St. Louis			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 Koch (rural)		c. LENGTH OF STAY (in this place) 67 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			d. STREET ADDRESS (If rural, give location) 4259 West Belle		

3. NAME OF DECEASED (Type or Print) a. (First) Lillian b. (Middle) - c. (Last) Otey			4. DATE OF DEATH (Month) (Day) (Year) March 29, 1949		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-17-13	9. AGE (In years last birthday) 35	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Tiff, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Willis Casey		13b. MOTHER'S MAIDEN NAME Mary Jane Roussan		14. NAME OF HUSBAND OR WIFE James Otey	
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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. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records, Robt. Koch Hosp.			
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs (?)
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 1-21-1949, to 3-29-1949, that I last saw the deceased alive on 3-29-1949, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE Harold G. Russell, M.D. (Degree or title)	23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 3-29-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-2-49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. 3-31-49	REGISTRAR'S SIGNATURE Harold G. Russell	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell and Co 2732 Pine
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Wm B. Brown  
Student Embalmer

Signed Clark Young

Licensed Embalmer No. 3371

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.