

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6261**
Registrar's No. **1110**

FILED FEB 27 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS MO -		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS 2049	
c. LENGTH OF STAY (in this place) TWO WEEKS		d. STREET ADDRESS (If rural, give location) 6618 VILLA AV.	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL - 4			

3. NAME OF DECEASED (Type or Print) a. (First) DAVID b. (Middle) JOSEPH c. (Last) BOTTO			4. DATE OF DEATH (Month) (Day) (Year) FEB 1 1952			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT 20 1897	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS	11. BIRTHPLACE (State or foreign country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME JOSEPH BOTTO	13b. MOTHER'S MAIDEN NAME JENNIE LONGNETTA	14. NAME OF HUSBAND OR WIFE MABEL BOTTO
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 714-10-9027	17. INFORMANT'S SIGNATURE OR NAME MRS. MABEL BOTTO	ADDRESS 6618 VILLA AV.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio nephritic - ANTECEDENT CAUSES A. Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. CNS Les. DUE TO (b) _____ 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
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? O26X

22. I hereby certify that I attended the deceased from **12-19-51** to **2-1**, 19**52**, that I last saw the deceased alive on **2-1**, 19**52**, and that death occurred at **8 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE PB Cappel (Degree or title) _____	23b. ADDRESS 3284 Ironhae me	23c. DATE SIGNED 2-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE FEB. 5, 1952	24c. NAME OF CEMETERY OR CREMATORY VAL HALLA CEMETERY	24d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY MO -
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DATE REC'D BY LOCAL REG. FEB 5 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE M. C. Coogan	ADDRESS 7146 Manchester
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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 *John Hetter*

Licensed Embalmer No. 3880

P. O. Address.....

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.