

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26187  
6946

DECEASED JUL 31 1952 BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>ST. LOUIS</i>		c. LENGTH OF STAY (in this place) <i>1 DAY</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>ALEXIAN BROS. HOSPITAL</i>		d. STREET ADDRESS (If rural, give location) <i>16 4100 HARTFORD ST.</i>	
3. NAME OF DECEASED (Type or Print) a. (First) <i>GEORGE</i> b. (Middle) c. (Last) <i>OTTO</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>JULY 17, 1952</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>NOV 10, 1869</i>
9. AGE (In years last birthday) <i>82</i>		10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED WATCHMAN SUPERVISOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RICE-STIX DRY WOODS CO.</i>	11. BIRTHPLACE (State or foreign country) <i>KOELZTOWN, MO.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13a. FATHER'S NAME <i>STEPHEN OTTO</i>	
13b. MOTHER'S MAIDEN NAME <i>KATHERINE BRUNNERT</i>		14. NAME OF HUSBAND OR WIFE <i>CAROLINE OTTO</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>495-12-4233A</i>	
17. INFORMANT'S SIGNATURE OR NAME <i>ELIZABETH C. OTTO</i>		ADDRESS <i>4100 HARTFORD ST.</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage.</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arterio Sclerosis "General"</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		<i>3316</i>	
22. I hereby certify that I attended the deceased from <i>July 13, 1952</i> , to <i>July 17, 1952</i> , that I last saw the deceased alive on <i>July 17, 1952</i> , and that death occurred at <i>4:30 A.M.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Julius S. Ketter</i> (Degree or title) <i>M.D.</i>		23b. ADDRESS <i>2603 Shooker St</i>	
23c. DATE SIGNED <i>7-18-52</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24b. DATE <i>July 19, 1952</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>S.S. PETER AND PAUL CEM</i>		24d. LOCATION (City, town, or county) (State) <i>ST. LOUIS, MO</i>	
DATE REC'D BY LOCAL REG. <i>JUL 18 1952</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Robert &amp; G. Co.</i>		ADDRESS <i>1905 So. GRAND</i>	

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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.

Student .....  
Student Embalmer

Signed

*Ronald O. Gohnde*

Licensed Embalmer No.

*3917*

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.