

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15673**
4212

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		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 ST. LOUIS		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3307 MINNESOTA.		e. STREET ADDRESS (If rural, give location) 3307 MINNESOTA. 2169			
3. NAME OF DECEASED (Type or Print) a. (First) LEON		b. (Middle)		c. (Last) FEL^o DOTTO	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY LABORER		10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		8. DATE OF BIRTH NOV 13 1910	
11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		9. AGE (In years last birthday) 42		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOSEPH FEL^o DOTTO		13b. MOTHER'S MAIDEN NAME CLARA		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 497-03-7576		17. INFORMANT'S SIGNATURE OR NAME ADDRESS CLARA FEL^o DOTTO 3309 MINNESOTA.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</p> <p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) Cerebral Apoplexy</p> <p>DUE TO (c)</p>		<p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 334X	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **6:45A** m., from the causes and on the date stated above.

23a. SIGNATURE Patricia L. Raynor (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4-23-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APR 25 1953		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis		ADDRESS 2906 Gravois	
DATE REC'D BY LOCAL REG. APR 23 1953		REGISTRAR'S SIGNATURE J. C. Smith			

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.....
Signature of Student Embalmer

Signed..... *James E. Dill*

Licensed Embalmer No. *4347*

P. O. Address *2501 1st Av*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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