

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20361  
State File No. \_\_\_\_\_  
Registrar's No. 4815

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4815	
1. PLACE OF DEATH a. COUNTY <u>Missouri</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>St. Louis, Mo.</u> b. COUNTY <u>2121</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (in this place) <u>17 DYS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>5351 Delmar</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Masonic Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5351 Delmar</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Fredrick</u> c. (Last) <u>Cutter</u>			4. DATE OF DEATH (Month) <u>5</u> (Day) <u>31</u> (Year) <u>1954</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>9-24-1865</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 1 MIN. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Hatfield, Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>John Alonzo Cutter</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Ann Wheeler</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Wangelin Cutter, Dec'd.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Masonic Home of Missouri, 5351 Delmar</u> <i>James Robertson</i>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>  ANTECEDENT CAUSES As forid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio-Sclerotic Heart Disease</u> 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 <u>3 Days</u>  <u>6 Mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4200</u>			
22. I hereby certify that I attended the deceased from <u>5-8-</u> , 19 <u>54</u> , to <u>5-31-</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5-31-</u> , 19 <u>54</u> , and that death occurred at <u>6 P.M.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>James Robertson</i>				23b. ADDRESS <u>508 Grand</u>		23c. DATE SIGNED <u>6-1-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		24b. DATE <u>6-1-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 1 1954</u>		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Alexander &amp; Sons 6175 Delmar Blvd.</u>			

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 \_\_\_\_\_

*No Embalming*

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

working under my personal supervision.

Signed *W. B. Gleyes*

Student .....  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

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.