

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 1 1955

State File No. 6707

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 381

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>CLAYTON</b>		c. LENGTH OF STAY (in this place) <b>1 DAY</b>	c. CITY OR TOWN <b>ST ANN 4071</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST LOUIS CO HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED a. (First) <b>Max</b> b. (Middle) _____ c. (Last) <b>Rotter</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>2-12-1955</b>	

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Feb. 16, 1867</b>	9. AGE (in years last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN SHOP</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>

13a. FATHER'S NAME <b>Unk. ROTTER</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>BERTHA ROTTER DECEASED</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JULIUS ROTTER 4525 CYPRESS</b>

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Cardiovascular Disease?</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <b>Cholecystitis and cholelithiasis, chronic?</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4221</b>	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?

22. I hereby certify that I attended the deceased from **2-11-1955** to **2-12-1955**, that I last saw the deceased alive on **2-12-1955**, and that death occurred at **2:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Cooper D. Ray M.D.</b> (Degree or title)	23b. ADDRESS <b>601 S. Brentwood</b>	23c. DATE SIGNED <b>2-12-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>2-15-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>LAKE WOOD PARK</b>
24d. LOCATION (City, town, or county) (State) <b>AFTON MISSOURI</b>		

DATE REC'D BY LOCAL REG. <b>2-14-55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Drake M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>EARL HILLEMANN 9709 LACKLAND OVERLAND</b>
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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 .....  
Signature of Student Embalmer

Signed *Earl F. Hellerman* .....

Licensed Embalmer No. *350*  
P. O. Addr. *Orlando* .....

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.