

FILED AUG 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24819**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **1697**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PINE LAWN | | c. CITY OR TOWN FLORISSANT | |
| c. LENGTH OF STAY (in this place) 3 yrs | | d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: SHAMROCK NURSING HOME | | e. STREET ADDRESS (If rural, give location) R. R. #1 | |

| | | | | | |
|--|--|-------------|---|-----------------------|--|
| 3. NAME OF DECEASED (Type or Print) ANTHONY | | | 4. DATE OF DEATH (Month) (Day) (Year) JULY 25 1955 | | |
| a. (First) | | b. (Middle) | | c. (Last) OTTO | |

| | | | | | |
|------------------------------|---|---|---|---|--|
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH JAN. 28, 1862 | 9. AGE (In years last birthday) 93 if under 1 year: Months _____ Days _____ if under 12 hrs: Hours _____ Min. _____ | |
|------------------------------|---|---|---|---|--|

| | | | |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER | 10b. KIND OF BUSINESS OR INDUSTRY GARDNING | 11. BIRTHPLACE (City and State or Foreign Country) Unknown | 12. CITIZEN OF WHAT COUNTRY? Unknown |
|--|---|--|---|

| | | |
|---|--|--|
| 13a. FATHER'S NAME UNKNOWN | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE UNKNOWN |
|---|--|--|

| | | | |
|--|---|--|--------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME PATRICK MCGHAN | ADDRESS 2331 Mullanphy |
|--|---|--|--------------------------------------|

| | | | |
|--|---|----------------|---|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH unknown |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease | | |
| | ANTECEDENT CAUSES Morbidity 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. Parkinson's Syndrome | | unknown | |

| | | |
|-------------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 4200 | 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? |

22. I hereby certify that I attended the deceased from **Aug 12, 1952** to **July 25, 1955**, that I last saw the deceased alive on **July 8, 1955**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

| | | | |
|---|-----------------------------|---|---|
| 23a. SIGNATURE Lewis Littmann MD | (Degree or title) MD | 23b. ADDRESS 8231 Clayton Rd | 23c. DATE SIGNED 7/25/55 |
|---|-----------------------------|---|---|

| | | | |
|--|------------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 24b. DATE 7/26/55 | 24c. NAME OF CEMETERY OR CREMATORY Calvary | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. |
|--|------------------------------------|---|--|

| | | | |
|---|--|---|----------------|
| DATE REC'D BY LOCAL REG. 7/25/55 | REGISTRAR'S SIGNATURE Herbert R. Donke, M.D. Dullen Kelly | 25. FUNERAL DIRECTOR'S SIGNATURE 7267 Natural Bridge | ADDRESS |
|---|--|---|----------------|

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 Not Embalmed, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James A. Lemmer

Licensed Embalmer No. 4113
P. O. Address St. Louis

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.