

14440

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1957

State File No. ....

3528

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>3528</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place) <b>LIFE</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DEACONESS HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>8723 ORIOLE AVE.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>OTTO</b>		b. (Middle) <b>- - -</b>		c. (Last) <b>BALTZER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 10, 1957.</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>MARCH 1, 1884.</b>	
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 MRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE AGENCY</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13a. FATHER'S NAME <b>JOHN BALTZER</b>			13b. MOTHER'S MAIDEN NAME <b>CAROLINE KNICKMEYER</b>			14. NAME OF HUSBAND OR WIFE <b>CLARA BALTZER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>488-10-1189</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS. CLARA BALTZER, 8723 ORIOLE AVE.</b>			
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) <b>glioma of frontal lobe</b> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>Pyelonephritis (chronic) Bronchopneumonia</b> 3 weeks				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
19a. DATE OF OPERATION <b>1955</b>		19b. MAJOR FINDINGS OF OPERATION <b>glioma of frontal lobe</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 <b>2-5, 1957</b> , to <b>4-10, 1957</b> , that I last saw the deceased alive on <b>4-10, 1957</b> , and that death occurred at <b>9:25P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>J. Earl Smith M.D.</b>				23b. ADDRESS <b>607 N. Grand Bl.</b>		23c. DATE SIGNED <b>4/12/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>4/13/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ZION CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO.</b>	
DATE REC'D BY LOCAL REG. <b>APR 12 '57</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 Natural Bridge Blvd. St. Louis, Mo.</b>			

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 *John A. Milman*.....  
Licensed Embalmer No...4186

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.