

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37436  
STATE FILE NUMBER  
9252  
REGISTRAR'S NO.

FILED OCT 21 1957

318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>S</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>/</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		Length of stay in 1b <b>15</b> d. STREET ADDRESS <b>224 2310 Cherokee St.</b> (If outside, give location)	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CHRIST</b> Middle <b>FOTTI</b> Last <b>FOTTI</b>		<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>2,</b> Year <b>1957</b>	
<b>5. SEX</b> Male <input checked="" type="checkbox"/>	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 1887
<b>9. AGE</b> (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Barber</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Barber</b>	
<b>11. BIRTHPLACE</b> (City and state or country) <b>Florina Greece</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Christ Fotti</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> _____	
<b>17. INFORMANT</b> <b>Helen Fotti</b>		Address <b>2310 Cherokee St.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>AZOTEMIA</b> (b): <b>MYOCARDIAL INFARCTION</b> (c): <b>CORONARY THROMBOSIS 420.1</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) ENCEPHALOMALACIA 2) RENAL CALCULI</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>  <b>7 DAYS</b>  <b>7 DAYS</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)	
<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____	
<b>21. I attended the deceased from</b> <b>SEPT. 24 1957</b> to <b>OCTOBER 2, 1957</b> and last saw <del>her</del> <b>him</b> alive on <b>10/2/57</b> Death occurred at <b>3:15 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> <i>Regina V. Hunsdel M.D.</i>		<b>22b. ADDRESS</b> <b>4401 Hoffman Ave</b>	
<b>22c. DATE SIGNED</b> <b>10/3/57</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>10/5/57</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Matthews Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Missouri</b>	
<b>24. FUNERAL DIRECTOR</b> <b>CHULICK UND. CO.</b>		ADDRESS <b>1722 S. Jefferson</b>	
<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 4 '57</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>J. Earl Smith, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

S.P.

Health, Welfare Public Service  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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**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 *Harmer W. Nuttz* .....

Licensed Embalmer No. *384*

P. O. Address *St. Louis* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.