

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041118

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3102

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 5 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>		a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rock Hill</b>		c. CITY OR TOWN <b>Rock Hill</b>	
Length of stay in 1b <b>11 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>812 Blossom Lane</b>		d. STREET ADDRESS (If outside, give location) <b>812 Blossom Lane</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <b>KATHRYN</b> Middle <b>HELEN</b> Last <b>OTT</b>			Month <b>Oct.</b> Day <b>26</b> Year <b>1962</b>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<b>Female</b>	<b>White</b>		<b>6-25-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (last birthday) <b>84</b>
		11. BIRTHPLACE (City and state or country) <b>Austria</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
13a. FATHER'S NAME <b>Unknown Zwerenz</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
14. NAME OF HUSBAND OR WIFE <b>Late Adam G. Ott</b>		17. INFORMANT Address <b>Helen Holtman 812 Blossom Lane</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>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1955</b>
DUE TO (b) <b>Hypertension</b>			<b>1955</b>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Feb. 1, 1955</b> to <b>October 26, 1962</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>October 26, 1962</b>		Death occurred at <b>7:35 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Donald Becke, M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>16-26-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 29, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshausner 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>10-26-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

**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 *R.W. Storrard*

Licensed Embalmer No. 4007

P. O. Address, St. Louis Mo

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.