

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

NOV 9 1935

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1003

34240

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis*

(No. *3238 Knapp St.*)

File No.....

Registered No.....

St. *8664* Ward.....

2. FULL NAME

Jacob J. Oetter

(a) Residence, No. *3238 Knapp St.* St. *26* Ward.....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 30/1858*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *76 11 14*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Copper*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Mallinckrodt Chem Co.*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Sea*

13. NAME *Not known*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Not known*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Mrs Mathilda Oetter 3238 Knapp St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *Breders Cem Oct 17 1935*

19. UNDERTAKER (ADDRESS) *Math Hermann & Son 5161 Fair Ave.*

20. FILED *15* 1935 *J. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 14*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *Oct 1* 19*35*, to *Oct 14*, 19*35*. I last saw him alive on *Oct 14*, 19*35*. Death is said to have occurred on the date stated above, at *2:55 P.* m.

The principal cause of death and related causes of importance were as follows: *Cerebral apoplexy* Date of onset

Other contributory causes of importance: *arteriosclerosis*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19..... Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no* If so, specify.....

(Signed) *Arthur S. Plummer*, M. D.

(Address) *3403 N 117*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

