

13475

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **3677**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 Wks.** (Specify whether
In this community **Life** years, months or days)

3. (a) PRINT FULL NAME **August Ottinger** **352**

3. (b) If veteran, name war. ----- 3. (c) Social Security No. **488-09-4482**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Married**

6. (b) Name of husband or wife **Minnie Chally** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **May 31 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 **10** **21** hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laboreg**

11. Industry or business **Elevator Operator**

MOTHER { 12. Name **Jacob Ottinger**
18. Birthplace **Germany**
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name **Christina Stoll**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Minnie Ottinger**
(b) Address **1927a Geyer Ave**

17. (a) **Burial** (b) Date thereof **Apr. 24 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Frederick J. ...**
(b) Address **1926 St. Louis Ave**

19. (a) **APR 23 1940** (b) **J. ...**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **1927a Geyer Av.** **23**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Louis Mo.**
(If rural, give location)
(e) **Physician** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr.** day **21**
year **1940** hour **1** minute **30**; **A.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple Myeloma**
pulmonary edema
Due to **fluidity undetermined**

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **53**
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) While at work _____ (e) Means of injury _____
23. Signature **Joseph M. ...** (Date) _____
Address **Deputy ...** Date Signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

1 X1931

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3737*

P. O. Address *1936 St. Xavier*

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 this body is not embalmed, above space should be left blank.