

No. 2
-5-43
5-17-43
FILED

Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **2399**

1. PLACE OF DEATH:

(a) County **Saint Louis**
(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7507 Oxford Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Clayton**
(If outside city or town limits, write "RURAL")
(d) Street No. **7507 Oxford Drive.**
(If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Bertha B. Otto

3. (b) If veteran, name war **Nil**

3. (c) Social Security No. **Nil**

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

6. (b) Name of husband or wife **A. A. Otto** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 16 1876**
(Month) (Day) (Year)

8. AGE: Years **67** Months **0** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Bloomington Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **W. Brennehan**

13. Birthplace **Unknown Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Roy H. Otto**

(b) Address **Wichita, Kansas**

17. (a) **Removal** (b) Date thereof **10-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wichita, Kansas**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **OCT 27 1944** (b) **C. W. Mc Garrison**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **25**
year **1943** hour **9** minute **00** P.M.

21. I hereby certify that I attended the deceased from **Oct. 21**, 19**43** to **Oct 25**, 19**43**
that I last saw her alive on **Oct 25**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Parenchymatous Nephritis with Uremia**
Due to **Chronic Myocarditis**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **1318**

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature **Roy C. Cauton** (M. D. or other)
Address **1222 1/2 E. 12th** Date signed **10/26/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

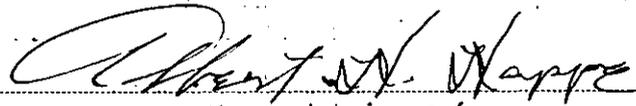
707

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..... 1861

P. O. Address.....

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, fact should be so stated above.