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7. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35697

State File No. ....  
Registrar's No. **10108**

**FILED** NOV 29 1945  
318  
Registration District No. ....

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(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 Ballwin, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Randy Joe Oetting  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, infant  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 20, 1945  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 22  
year 1945 hour 6:45 minute A. M.  
21. I hereby certify that I attended the deceased from Nov. 20, 1945 to Nov. 22, 1945  
that I last saw him alive on Nov. 21, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

Immediate cause of death Status thymico-lymphaticus  
Due to \_\_\_\_\_  
Due to Wt  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Infant  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Alexander Charles Oetting  
13. Birthplace Tebbets, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mildred Gladys Phillips  
15. Birthplace Tebbets, Mo.  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mr. A. Oetting  
(b) Address Ballwin, Mo. P.O. #7  
17. (a) Burial (b) Date thereof 11-23-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation BAPTIST Cem. Ballwin, Mo.  
18. (a) Signature of funeral director SCHRADER FUNERAL HOME  
(b) Address BALLWIN, MO.  
19. (a) NOV 23 1945 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_  
23. Signature B. R. Loving (M. D. or other) MD  
Address Ballwin, Mo. Date signed 11-22-45

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

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

Signed.....

*not Embz*

Licensed Embalmer No.....

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.**