. S. No. 2
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v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42486

FILED DEC 28 1945

Registration District No. 567 Primary Registration District No. 3069 Registrar's No. 2879

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town ~~St. Louis Missouri.~~ Richmond Hts.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hospital ~~Clayton~~ Hts.
(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 Ado

(c) City or town St Louis. 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1332a Shenadoah Av. 9
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME Frank G. Otto.

3. (b) If veteran, name war NO

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

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec (Month) 3 (Day) 1876 (Year)

8. AGE: Years 69 Months 0 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace St Louis Missouri. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Grocery Clerk.

11. Industry or business .....

FATHER
12. Name Philip Otto.
13. Birthplace St Louis Missouri. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sophie Klein
15. Birthplace St Louis Missouri. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Otto

(b) Address 1332a Shenadoah Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery.

18. (a) Signature of funeral director Wm C Moydell

(b) Address 1926 Allen Av.

19. (a) 12-20-45 (Date received local registrar) (b) E G McGarran M D (Registrar's signature) M Sa

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 16 year 1945 hour 2 minute 5 P.M.

21. I hereby certify that I attended the deceased from Dec 19 1945, 19..., to Oct 20, 1945; that I last saw him alive on Oct 20, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma Mandible	
Due to: 45d	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
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 W E Leighton (M. D. or other) M.D.

Address 3720 Washington Date signed 12/18/45

(Licensed Embalmer's Statement on Reverse Side)

JAN 10 1945

MAR 18 1945

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 Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

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.