

S. No. 2
1-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43097

State File No. _____
Registrar's No. 10687

FILED DEC 24 1946
Registration District No. 378

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:
DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether _____)
In this community 28 years
(years, months or days)

3. (a) PRINT OTTILIA MARIE WHITE
FULL NAME
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Leslie P. White
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased July 4, 1918
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
28 5 8 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Chanitz
13. Birthplace Austria
(City, town, or county) (State or foreign country)
14. Maiden name Marie Hofer
15. Birthplace Austria
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie P. White
(b) Address 4220 John Avenue

17. (a) Burial (b) Date thereof 12-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 2117 East Grand Blvd.

19. (a) DEC 12 1946 (b) [Signature]
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 00-0
(c) City or town St. Louis 1017
(If outside city or town limits, write "RURAL")
(d) Street No. 4220 John Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12th
year 1946 hour 8 minute 15 A.M.
21. I hereby certify that I attended the deceased from 15 March
1946 to 12 Dec. 1946
that I last saw her alive on 11 Dec. 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary hemorrhage 5 min.
Duration

Due to Generalized
Due to Lymphosarcoma

Other conditions
(Include pregnancy within 3 months of death)
55

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? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature John F. Shaver (M. D. or other)
Address 607 N. Grand Date signed 12/12/46

L. John T. Straker
George
University Club Bldg.

30411

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 *Frank A. Moore*

Licensed Embalmer No. *30411*

P. O. Address *2117 1/2*

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.