S. No. 2
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PI X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2342

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1004

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Lukes Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 Days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis Co 0

(c) City or town 6306 Spencer Place - Wellston, Mo (If outside city or town limits, write "RURAL")

(d) Street No. NR 0 (If rural, give location)

(e) Citizen of foreign country? (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME Otto Claussen

3. (b) If veteran, name war

3. (c) Social Security No. 489-05-6748

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Dollie Claussen

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

7. Birth date of deceased Nov (Month) 9 (Day) 1907 (Year)

8. AGE: Years 39 Months 2 Days 19 If less than one day hr. min.

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

10. Usual occupation Machinist

11. Industry or business Lincoln Engineer

MOTHER FATHER

12. Name John Claussen

13. Birthplace New York (City, town, or county) (State or foreign country)

14. Maiden name Olga Meenike

15. Birthplace N. Y. (City, town, or county) (State or foreign country)

16. (a) Informant Dollie Claussen

(b) Address 6306 Spencer Place

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Mo Cemetery

18. (a) Signature of funeral director Central Und Co.

(b) Address 1841 Cass ave

19. (a) JAN 30 1947 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28 year 1947 hour 10:00 minute P. M.

21. I hereby certify that I attended the deceased from Jan. 7, 1947, to Jan. 28, 1947, that I last saw him alive on Jan. 28, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Lung	3 mo
Due to: Carcinoma of Kidney	1 yr
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 0

23. Signature K. F. Slack (M. D. or other)

Address 3720 Washington Date signed 1/30/47

(Licensed Embalmer's Statement on Reverse Side)

CA 6101
NP 2821

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 Henry M. Brammer

Licensed Embalmer No. 4200

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.