S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10547

FILED APR 7 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3174

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WRITE PLAINLY—USING 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: DEACONNESS HOSPITAL 0
(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: 000

(a) State Mo (b) County

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

(d) Street No. 617 DOVER PL. 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME GERTRUDE OTTE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife Wm F. OTTE

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased MAY (Month) 2nd (Day) 1882 (Year)

8. AGE: Years 65 Months 10 Days 28 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name JOHN STEWART
13. Birthplace ILL (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name JULIA HART
15. Birthplace Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant Wm F. Otte
(b) Address 617 Dover Pl.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/2/48 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM

18. (a) Signature of funeral director L. Mullen Ward Co
(b) Address 5165 Delmar Bl.

19. (a) APR 1 1948 (Date received local registrar) (b) J. F. Brasick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MCH. day 30th
year 1948 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb. 12, 1948, to March 30, 1948
that I last saw her alive on March 30, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
Metastatic Carcinoma (hysterectomy from carcinoma of cervix 1944)

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Not performed

Duration

PHYSICIAN

Underline the cause of 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 Robert C. Hengeland (M. D. or other) M.D.
Address 31 N. Bunteroad, Dayton 5, Mo. Date signed 3-31-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. H. G. Farris

Licensed Embalmer No. 3384

P. O. Address St. Louis

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.