

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21539  
Registrar's No. 1400

FILED JUL 6 1948  
Registration District No. 247

Primary Registration District No. 3863

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town CLAYTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. LOUIS COUNTY HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 MINUTES  
(Specify whether  
In this community 16 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS 96  
(c) City or town SAPPHINGTON 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Box 2000 Rt. # 6 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HARVEY VATTEROTT JR.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 10 5 1931  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
16 7 27 hr. 0 min.

9. Birthplace ST. LOUIS COUNTY MISSOURI  
(City, town, or county) (State or foreign county)

10. Usual occupation BRECKHALE APPRENTICE

11. Industry or business VATTEROTT REALTY CO.

12. Name HARVEY VATTEROTT JR.

13. Birthplace W. St. Charles MO  
(City, town, or county) (State or foreign county)

14. Maiden name ETHEL BESNER

15. Birthplace W. St. Charles MO  
(City, town, or county) (State or foreign county)

16. (a) Informant HARVEY VATTEROTT JR.

(b) Address Box 2000 Rt. # 6 Sappington

17. (a) Burial (b) Date thereof 6-5-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary

18. (a) Signature of funeral director William F. Stone

(b) Address 12123 St. Charles Rd.

19. (a) 6-4-48 (b) Gene A. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 2  
year 1948 hour 12 minute 05 a.m.

21. I hereby certify that I attended the deceased from JUNE 1,  
1948, to JUNE 2, 1948,  
that I last saw him alive on JUNE 2, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of skull and of 2, 3, 4, 5 ribs left with hemothorax  
Due to \_\_\_\_\_

Due to 170 C-8

Other conditions #22  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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) ACCIDENT (TRAF.)

(b) Date of occurrence JUNE 1-1948 96

(c) Where did injury occur? LINDBERGH Sq. of N. 11th St.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
PUBLIC HIGHWAY  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury AUTO ACC.

23. Signature Wilson Brown (M. D. or other) MD  
Address 601 Brentwood Date signed 6-4-48

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

MOTHER FATHER

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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.....

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.**

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

# STANDARD CERTIFICATE OF DEATH

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 30 Minutes  
(Specify whether years, months or days)

In this community Life Time  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Sappington Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. Box 2000 Rt. 6  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME J. Harvey Vatterott Jr.

3. (b) If veteran, name war None

3. (c) Social Security No. 496 32 0858

4. Sex Male 5. Color or race White

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

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

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

7. Birth date of deceased Oct. 5 1931  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>16</u>	<u>7</u>	<u>26</u>	..... hr. .... min.

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

10. Usual occupation Apprentice Brick Layer

11. Industry or business .....

12. Name J. Harvey Vatterott

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

14. Maiden name Ethel Bishop

15. Birthplace St. Charles Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant J. Harvey Vatterott

(b) Address Box 2000 Rt. 6 Sappington Mo.

17. (a) Burial (b) Date thereof 6/5/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Colliers Funeral Home

(b) Address 10123 St. Charles Rd.

19. (a) ..... (b) .....  
(Date received local registrar) (Registrar's signature)

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1  
year 1948 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....  
that I last saw h..... alive on ..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

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

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

Major findings:  
Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

MOTHER FATHER

S-21539

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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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Chas.

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.