

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 27848  
7524  
Registrar's No.

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Firmin Desloge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 months  
(Specify whether  
In this community 30 years  
years, months or days)

3. (a) PRINT  
FULL NAME

Hutter, Fred

3. (b) If veteran,  
name war

Nil

3. (c) Social Security No.  
498-03-2974

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Christina  
6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased January 4, 1881  
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 22  
If less than one day  
hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

12. Name John Hutter

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

14. Maiden name unknown

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

16. (a) Informant Christina Hutter

(b) Address 1518 So. 11th Street

17. (a) Burial (b) Date thereof 8/30/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valmeyer, Illinois

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) Aug 27 1948

(Date received local registrar)

(b) J. Z. Breeden  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County and  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1518 So. 11th Street  
23 (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8-26-48 day  
year \_\_\_\_\_ hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from  
5-17-48 to 8-26-48, 19\_\_\_\_;  
that I last saw him alive on 8-26-48, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia  
Due to aspiration of food  
Due to aspiration of food

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy aspiration of food

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)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. Z. Breeden (M.D. or R.N.)  
Address 1321 S. Grand Date signed 8/27/48

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..... *C. H. Cooper*

Licensed Embalmer No..... *3830*

P. O. Address..... *2301 Lafayette*

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.