

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28601

#98393

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State File No. \_\_\_\_\_

7473

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>				d. STREET ADDRESS (If rural, give location) <b>20 - 3728a Vest Ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b> b. (Middle) _____ c. (Last) <b>SUTTER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>August 26, 1949</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>Jan. 18-1887</b>		
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tool &amp; die maker</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Adolph Sutter</b>			13b. MOTHER'S MAIDEN NAME <b>Barbara Eggs</b>			14. NAME OF HUSBAND OR WIFE <b>Emma Costello Sutter</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Emma Costello Sutter</b> ADDRESS <b>3728a Vest Ave</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>								
MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Emphysema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>113</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>5:27!</b>				
22. I hereby certify that I attended the deceased from <b>6/11/49</b> , 19____, to <b>8/26/49</b> , 19____, that I last saw the deceased alive on <b>8/26/49</b> , 19____, and that death occurred at <b>4:55 pm.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>John W. Murphy Jr MD</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Ave.</b>		23c. DATE SIGNED <b>8/27/49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-30-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Pickers Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>		
DATE REC'D BY LOCAL REG. <b>AUG 29 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sauter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leidner U.</b> ADDRESS <b>2223 St. Louis Ave.</b>				

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Albert L. Happen

Licensed Embalmer No. 2971

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.