

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35182

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8733**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) Rock Hill	
c. LENGTH OF STAY (in this place) 3 1/2 hours		d. STREET ADDRESS (If rural, give location) 221-923 8 Manchester	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hosp.		4. DATE OF DEATH (Month) (Day) (Year) 10 9 49	
3. NAME OF DECEASED a. (First) Steven b. (Middle) Howard c. (Last) Gutman		5. SEX male 6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) U		8. DATE OF BIRTH 11-10-46	
9. AGE (in years last birthday) 2 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) St. Louis Mo	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis H. Gutman		13b. MOTHER'S MAIDEN NAME Daisy Block	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) MA	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME MO LOUIS GUTMAN	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ADDRESS 9238 Manchester	

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Osteopetrosis		INTERVAL BETWEEN ONSET AND DEATH 35 mo.	
ANTECEDENT CAUSES Morbidity 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. Intracranial Hemorrhage			

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) 157th MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7386	

22. I hereby certify that I attended the deceased from **10-9**, 1949, to **10-9**, 1949, that I last saw the deceased alive on **10-9**, 1949, and that death occurred at **11:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. G. Klingberg M.D.		23b. ADDRESS Children's Hosp.		23c. DATE SIGNED 10/9/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 10/11/49		24c. NAME OF CEMETERY OR CREMATORY Mc SIMAI	
24d. LOCATION (City, town, or county) (State) St. Louis					

DATE REC'D BY LOCAL REG. OCT 10 1949		REGISTRAR'S SIGNATURE J. B. Bassett		25. FUNERAL DIRECTOR'S SIGNATURE Bergin Memorial - 4715 The Plaza	
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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 *Thurs Auding*

Licensed Embalmer No. 4229

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.