

31805

State File No.

7832

FILED SEP 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHBIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>1627 CARROLL ST.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>OTTO</u> b. (Middle) <u>-</u> c. (Last) <u>MAESER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 13 1950</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>5</u>	8. DATE OF BIRTH <u>DEC. 24, 1874</u>
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>PHILLIP MAESER</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA MARGARET ERB</u>	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>EMIL MAESER 2133 ALLEN</u>	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> 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 type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>331X</u>		22. I hereby certify that I attended the deceased from <u>3-16-1948</u> , to <u>9-13-1950</u> , that I last saw the deceased alive on <u>9-13-1950</u> , and that death occurred at <u>6⁰⁰P</u> m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>Andrew J. Klein, M.D.</u>		23b. ADDRESS <u>4632 So Grand</u>	
23c. DATE SIGNED <u>9-15-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>SEPT. 16 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NEW PACKER CEM.</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Gravois</u>	
DATE REC'D BY LOCAL REG. <u>SEP 15 1950</u>		REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

James E. Hill

Signed.....
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2506 Travis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.