

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28769  
7833

No. 300  
10.48

FILED SEP 13 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY - 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri, MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) 37. LOUIS, MO.		c. LENGTH OF STAY (in this place) 25	
d. FULL NAME OF HOSPITAL OR INSTITUTION 37. LOUIS CITY HOSP. #1		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2259	
		d. STREET ADDRESS (If rural, give location) 14 N. 18th St. 0	
3. NAME OF DECEASED a. (First) ARTHUR		b. (Middle) SUTTER	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 9 1 1951	
5. SEX MO	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH May 17, 1893 3
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CLERK	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0
10b. KIND OF BUSINESS OR INDUSTRY Post Office		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Michael Sutter		13b. MOTHER'S MAIDEN NAME Barbara Good	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Mathilda Krueger, 4421 Bryant	
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) Malnutrition Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Psychosis with cerebral arteriosclerosis 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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 204X			
22. I hereby certify that I attended the deceased from 8-28, 1951, to 9-1, 1951, that I last saw the deceased alive on 9-1, 1951, and that death occurred at 12:35 p.m., from the causes and on the date stated above.			
23a. SIGNATURE W. J. Rutledge (Degree or title) M.D.		23b. ADDRESS St. Louis City Hwy	
23c. DATE SIGNED 9-2-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-5-51	
24c. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery		24d. LOCATION (City, town, or county) (State) 6638 Gravois	
DATE REC'D BY LOCAL REG. SEP 4 1951		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	

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

SEP 26 1951

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

Licensed Embalmer No. 3653

P. O. Address Spokane, Wash

**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.