

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42683
11038

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY OR TOWN <u>Saint Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Saint Louis</u>		<u>3109</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Firmin Desloge Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3211 Barrett Street, 7,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GUSTAVE</u>		b. (Middle) <u>H.</u>		c. (Last) <u>OTTING</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 1st, 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 10th, 1878</u>		9. AGE (In years last birthday) <u>76</u>	10. MONTHS _____	11. DAYS _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Otting</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Moehlenkamp</u>		14. NAME OF HUSBAND OR WIFE <u>Marguerite Otting</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marguerite Otting, 3211 Barrett St. 7</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Congestive Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>8 yrs.</u>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4200</u>			
22. I hereby certify that I attended the deceased from <u>6-1</u> , <u>1954</u> , to <u>Dec 1</u> , <u>1954</u> , that I last saw the deceased alive on <u>Dec 1, 1954</u> , and that death occurred at <u>4:45P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ka Kunsella M.D.</u>		23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>12/2/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12/4/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>DEC 3 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo.</u>			

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

Je. 3-5100

Hours between 3:00PM & 5:00PM
Thursday sure

File in City

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 *John A. Mlinar*

Licensed Embalmer No. *486*

P. O. Address *St. Louis Mo.*

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.