

FILED MAY 16 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14364  
Registrar's No. 26

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 6078

|   |  |   |                       |
|---|--|---|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>STE. Genevieve</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>STE. Genevieve</u> |                       |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL JACKSON</u> |  | c. LENGTH OF STAY (In this place) <u>LIFE</u>   | c. CITY OR TOWN _____ |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BLOOMSDALE, Mo. STAR ROUTE</u>                         |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                 |                       |
|   |  | e. STREET ADDRESS (If rural, give location) <u>BLOOMSDALE Mo - STAR ROUTE</u>   |                       |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>HENRY</u> b. (Middle) <u>John</u> c. (Last) <u>OTTE</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 11 1955</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>Feb 24, 1878</u>   |  | 9. AGE (In years last birthday) <u>77</u> |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> |  |
| 10a. USUAL OCCUPATION  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>LAWRENCETOWN, Mo</u>                               |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME <u>William F. OTTE</u>                                  |  | 13b. MOTHER'S MAIDEN NAME <u>MARY SCHMIDT</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Alice D. Hester</u>                   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> |  | 16. SOCIAL SECURITY NO. <u>None</u>           |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Wm Otte, Lawrence town, Mo.</u> |  |
|  |  |   |  | ADDRESS _____  |  |

|   |  |  |  |  |   |  |
|---|--|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>20 yrs</u> |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arterio-Sclerosis</u> |  |  | <u>20 yrs</u>                                     |  |
|   |  | DUE TO (c) _____   |  |  |   |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>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) _____ |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? _____   |  |

22. I hereby certify that I attended the deceased from 19 29 May 11 1955, to MAY 10 1955, that I last saw the deceased alive on MAY 10 1955, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

|   |  |                                       |  |                                 |  |
|---|--|---------------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <u>Thomas E. [Signature]</u> (Degree or title) <u>M.D.</u> |  | 23b. ADDRESS <u>Ste. Genevieve Mo</u> |  | 23c. DATE SIGNED <u>5-12-55</u> |  |
|---|--|---------------------------------------|--|---------------------------------|--|

|   |  |                            |  |   |  |
|---|--|----------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> |  | 24b. DATE <u>May 14-55</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>ST. LAWRENCE</u>                |  |
|   |  |                            |  | 24d. LOCATION (City, town, or county) (State) <u>Lawrencetown, Mo</u> |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>May 13, 1955</u> |  | REGISTRAR'S SIGNATURE <u>Luella Barber</u> 481 |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Les C. Basler</u> ADDRESS <u>Ste. Genevieve, Mo</u> |  |
|--|--|--|--|---|--|

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

MAY 18 1955

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.....  
Signature of Student Embalmer

Signed *Adrian J. Miller*.....  
Licensed Embalmer No. *474*  
P. O. Address *St. Genevieve*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.