

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6763

State File No.

318

1003

1470

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital				e. STREET ADDRESS (If rural, give location) 24 3225 So. Jefferson 2249			
3. NAME OF DECEASED (Type or Print) a. (First) Otto b. (Middle) _____ c. (Last) Kluskey			4. DATE OF DEATH (Month) (Day) (Year) Feb. 8, 1954				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Sept. 19, 1887		9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired watchman			10b. KIND OF BUSINESS OR INDUSTRY Public Library		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unavailable			13b. MOTHER'S MAIDEN NAME Unavailable		14. NAME OF HUSBAND OR WIFE Unavailable		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Alexian Bros. Hospital Records ADDRESS _____			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hypertensive Heart Disease. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443X					INTERVAL BETWEEN ONSET AND DEATH One Day 1 1/2 yrs
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input 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) _____		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"/>
21d. TIME OF INJURY _____		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 1-14 , 19 54 , to 2-8 , 19 56 , that I last saw the deceased alive on 2-8 , 19 56 and that death occurred at 2 p. m., from the causes and on the date stated above.							
23a. SIGNATURE Julius Ehas Rotten M.D. (Degree or title)				23b. ADDRESS 2603 Sherwood St.		23c. DATE SIGNED 2-10-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) cremation		24b. DATE 2-11-56	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
DATE REC'D BY LOCAL REG. FEB 10 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Morrell Funeral Home ADDRESS 4212 St. Louis			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

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 *Bluma F. Gaddwell*.....

Licensed Embalmer No. *407*.....

P. O. Address *H. L.*.....

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.