

Health,
& Welfare
Public
Service

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37603

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10028

S. 300
1-57

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		d. STREET ADDRESS <u>116 No. 8th</u> <u>Mark Twain Hotel</u>	

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Henry</u> Last <u>Hortop</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1957</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1880</u>	9. AGE (In years last birthday) <u>77yrs</u>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Appraiser</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>American Appraisal Co.</u>	11. BIRTHPLACE (City and state or country) <u>Walkerville, Ontario, Canada</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Hortop</u>	13b. MOTHER'S MAIDEN NAME <u>Helen G. Shanks</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Hortop</u>
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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>497-05-0287</u>	17. INFORMANT <u>Mrs. O. Howard Cox 11318S/W Military Rd.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DIS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>420.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CEREBRAL EMBOLISM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>8/19/54</u> to <u>10/25/57</u> and last saw him alive on <u>10/25/57</u> Death occurred at <u>12:45</u> p.m. or of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>David Selendy, MD</u> (Degree or title)	22b. ADDRESS <u>539 N. GRAND ST LOUIS, MO</u>	22c. DATE SIGNED <u>10/26/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 28, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>Alexander & Sons 6125 Delmar</u>	ADDRESS <u>6125 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 26 57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith - MD</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. David Fellman
601 Humboldt Bldg
012-1003
Lindell E. Eichel
T. 12.

NOV 26 1957

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 *jos. a. McCulloh*

Licensed Embalmer No. *2460*
P. O. Address *675 Delmar*

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.