

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9189

FILED OCT 13 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 327 Antelope St
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last SUTTER			4. DATE OF DEATH Month OCTOBER Day 4 Year 1961			
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/30/07	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tool maker	10b. KIND OF BUSINESS OR INDUSTRY Universal Metal	11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME George Sutter	13b. MOTHER'S MAIDEN NAME Kunidunda Hoffmann	14. NAME OF HUSBAND OR WIFE Marie Sutter
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT Marie Sutter, 327 Antelope St., Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIAC FAILURE		LESS THAN 1 HOUR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) INFERCEREBRAL METASTASES	1 MONTH
	DUE TO (c) BRONCHOGENIC CARCINOMA 162.1	10 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 **JANUARY 29, 1961** to **OCTOBER 4, 1961** and last saw her/him alive on **OCTOBER 4, 1961**
Death occurred at **2:15 A. M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Vermillion, M. D.</i> (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/4/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/7/61	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.	(State)
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24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8319 Hallsferry	ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 5 1961	26. REGISTRAR'S SIGNATURE <i>Roald Smith, M. D.</i>
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ST. LOUIS, MISSOURI

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NO.

ON (date of)

DECEASED (name)

AGE (years)

RESIDENCE (address)

CAUSE OF DEATH (diagnosis)

PLACE OF BURIAL (name)

DATE OF INTERMENT (date)

TIME OF INTERMENT (time)

BY (name)

LOCAL BOARD NO.

STATEMENT BY LICENSED EMBALMER

EMBALMER

STATE OF MISSOURI

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 *John J. Haines*
Licensed Embalmer No. 4108

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