LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20352

PLACE OF DEATH
County St. Louis — Registration District No. 790 — File No.
Township Central — Primary Registration District No. 6033 — Registered No. 54
City (No. 7404 Ethel av St. Ward)

FULL NAME Louise Obenhaus

(a) Residence. No. 7409 Wise av St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
th of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	White	Widow

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Henry A Obenhaus

ATE OF BIRTH (MONTH, DAY AND YEAR) Sep 29 1844

GE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	75			

CCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

IRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

10. NAME OF FATHER Simon Brandt

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Sophia Brandt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

INFORMANT Albert J Obenhaus
(Address) 7409 Wise av

FILED 5-30 1920 J. B. Sudduth
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1920

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ help an unqualified ..., 19..., to ..., 19...
that I last saw h..... alive on ..., 19..., and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
valvular heart lesion

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R B Denny Corner M.D.
5-29, 1920 (Address) Crene Coeur Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bellefontaine Cemetery	June 1 1920

20. UNDERTAKER	ADDRESS
Geo. Kingshaum	4407 Manchester av

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ..., St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL

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