

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.

OCT 4 1937

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

32378

Do not use this space.

1. PLACE OF DEATH

(a) County.....

Registration District No.....

(b) Township.....

Primary Registration District No.....

(c) City.....

(d) Street No..... City Hospital No.1

(e) Length of residence in city or town where death occurred

58 yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) St. City Hospital No.1

C. 7673

2. PRINT FULL NAME

August Obenhaus

(a) Residence, No.....

5720 a East Virginia

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR

Divorced (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Mary

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

Aug. 8, 1879

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

58

0

29

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work
was done, as saw mill, bank, etc.

packer porter

10. Date deceased last worked at
this occupation (month and
year).....

11. Total time (years)
spent in this
occupation.....

12. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis, Missouri

13. NAME

August Obenhaus

14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

15. MAIDEN NAME

Dorothy Garst

16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

17. INFORMANT

(ADDRESS)

Hosp. Info M. Kent

City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL

PLACE.....

DATE Sept. 9

1937

19. FUNERAL DIRECTOR

(ADDRESS)

C. Hoffmeister U. & L. Co.

7814 S. Broadway

20. FILED

SEP 7 1937

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Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/7/37, 19

22. I HEREBY CERTIFY, That I attended deceased from

8/29/37

19

to

9/7/37

19

I last saw him alive on 9/7/37, 19

Death is said to have occurred on the date stated above, at 1.45 a

The principal cause of death and related causes of importance were as follows:

Perforated gastric ulcer
Peritonitis, general.
secondary

Other contributory causes of importance:

117a

Name of operation Cholecystectomy Date of 9/29/37

What test confirmed diagnosis? Operation Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed).....

(Address).....

City Hospital No.1

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, George W. Hoffmeister, Licensed Embalmer No. 2426

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Leo. J. Bydde

L. E. #3989

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 2426

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.)