

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

REC'D SEP 7 1939

Registration District No. 784

Primary Registration District No. 115

Registrar's No. 1441

1. PLACE OF DEATH:

(a) County ST. LOUIS COUNTY MO

(b) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8687 FANNIE AVE. 2
(If dot in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 32 YEARS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS COUNTY MO

(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 8687 FANNIE AVE.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ENTIRE LIFE years.

3. (a) PRINT FULL NAME CATHERINE A. OCHTERBECK

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month August day Twelfth
year 1939 hour 3 minute 00 a.m.

21. I hereby certify that I attended the deceased from May 26, 1939, 1939, to August 11, 1939;
that I last saw her alive on August 11, 1939;
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN D. OCHTERBECK

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased JANUARY 24TH 1868
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis
Arterio-sclerosis, generalized.

Duration ?
?

8. AGE: Years 71 Months 7 Days 19
If less than one day — hr. — min.

Due to 930

Due to 930

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

Other conditions Varicose ulcers, both legs.
(Include pregnancy within 3 months of death)

10. Usual occupation HOUSE-WORK

11. Industry or business AT HOME

PHYSICIAN —

Underline the cause to which death should be charged statistically.

Major findings:
Of operations —

Of autopsy —

MOTHER FATHER { 12. Name JOSEPH NOLTE

13. Birthplace GERMANY
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name ANNA ODELEHR

15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. D. Ochterbeck

(b) Address 8687 Fannie Ave. U.C.

17. (a) BURIAL (b) Date thereof AUG 14TH 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State) —

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

18. (a) Signature of funeral director Brockland and Co

(b) Address 1827 Hogan St. St. L.

19. (a) AUG 12 1939 (b) J. R. Meyer
(Date received local registrar) (Registrar's signature)

23. Signature John R. Daly M.D. (M. D. or other) —

Address 37 N. Meramec Date signed 8/12/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Guy W Wilkinson

Licensed Embalmer No.

3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.