

**JUL 15 1940**

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1078

**1. PLACE OF DEATH:**  
 (a) County St. Louis  
 (b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number and location)  
 (d) Length of stay: In hospital or institution 6 days  
(Specify whether

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo. (b) County St. Louis  
 (c) City or town Hillemay St. & Butler Hill Rd.  
(If outside city or town limits, write "RURAL")  
 (d) Street No Highway 61 & Butler Hill Rd.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.?

In this community  
years, months or days

**3. (a) PRINT FULL NAME** George Bechtold 234

**3. (b) If veteran,** name war ? **3. (c) Social Security** No. ?

**4. Sex** male **5. Color or race** white **6. (a) Single, widowed, married, divorced** single

**6. (b) Name of husband or wife** **6. (c) Age of husband or wife if** alive          years

**7. Birth date of deceased** April 4 1862  
(Month) (Day) (Year)

<b>8. AGE:</b>	Years	Months	Days	If less than one day
	78	2	0	hr. <u>        </u> min.

**9. Birthplace** St. Louis County Mo.  
(City, town, or county) (State or foreign country)

**10. Usual occupation** nil.

**11. Industry or business** h

**MOTHER FATHER**

**12. Name** John Bechtold  
**13. Birthplace** Unknown Germany  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Frances Bouncer  
**15. Birthplace** Unknown Germany  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Arthur Jensemans

**(b) Address** Matthaeus mo

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** June 7 1940  
(Month) (Day) (Year)

**(c) Place: burial or cremation** matthaeus mo

**18. (a) Signature of funeral director** Joseph Lindes

**(b) Address** 743 1940

**19. (a) JUN 15 1940** (Date received local registrar) Dr. R. M. ... (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month June day 4  
year 1940 hour 9 minute :40 P.M.

**21. I hereby certify that I attended the deceased from** 5-29-40  
19 to 6-4-40, 19  ;  
that I last saw him alive on 6-4-40, 19  ;  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Bronchial Pneumonia</u>	<u>2 day</u>
<u>Pulmonary Stasis</u>	<u>5 day</u>
<u>Myocardial Failure</u>	<u>2 week</u>

**Other conditions**  
(Include pregnancy within 3 months of death)

**Major findings:**  
Of operations 107  
Of autopsy         

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

**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?**

**701** (Specify type of place)  
While at work? **(e) Means of injury**

**23. Signature** Dr. R. M. ... (M. D. or other)  
**Address** 743 1940 **Date signed** 6/15/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

26  
2  
2

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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

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