

SEP 25 1940

Registration District No. 642

Primary Registration District No. 5851

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Osage
(b) City or town Westphalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 85 years. (years, months or days)

3. (a) PRINT FULL NAME Mrs. Anna Fechtel

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Conrad Fechtel 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 6, 1855
(Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 14 If less than one day hr. _____ min. _____

9. Birthplace Westphalia, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Borgmeter 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Johanna Fennewald 9
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Fechtel
(b) Address Westphalia, Missouri

17. (a) Burial (b) Date thereof Aug. 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westphalia, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Jefferson City, Missouri

19. (a) 9/21/40 (b) Man. L. Plager
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage
(c) City or town Westphalia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1940 hour 12 minute 55 A M.

21. I hereby certify that I attended the deceased from Aug 13 1940 to Aug 19 1940
that I last saw her alive on Aug 19 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Tuberculosis

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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? 573

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

23. Signature Dr. L. A. Beecher (M. D. or other) _____
Address Jefferson City, Mo Date signed 9/21/40

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

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

1096

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 *John G. Smith*

Licensed Embalmer No. 3655

P. O. Address Jefferson City, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29272**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **642**

Primary Registration District No. **5851**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Wash**
(b) City or town **Westphalia T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mrs Anna Fechtel**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **85** Months **-** Days **14** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace. (City, town, or county) (State or foreign country)
14. Maiden name. _____ (State or foreign country)
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH. Month **Aug** day **20**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration _____

Due to **Bronchial**
Due to **107W**

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

Major findings:
Of operations _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

