

FILED AUG 9 1944  
319

Registration District No. 319

Primary Registration District No. 6079

Registrar's No. 33

1. PLACE OF DEATH:  
(a) County. STE. GENEVIEVE  
(b) City or town. RURAL STE. GENEVIEVE TWP  
(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 1  
  
In this community LIFE  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. MISSOURI (b) County. STE. GENEVIEVE  
(c) City or town. RURAL 95  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. St. Genevieve Twp. 0  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country. 0

3. (a) PRINT FULL NAME ODILE BAECHE  
3. (b) If veteran, name war. 0 3. (c) Social Security No. 0

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife. HENRY C. BAECHE 6. (c) Age of husband or wife if alive 49 years  
7. Birth date of deceased. JULY 22 1896  
(Month) (Day) (Year)

8. AGE: Years 48 Months 5 Days 9 If less than one day 0 hr. 0 min.

9. Birthplace. STE. GENEVIEVE CO MO 0  
(City, town, or county) (State or foreign country)

10. Usual occupation. HOUSEWIFE

11. Industry or business. 0

MOTHER FATHER

12. Name. JOHN FALLERT

13. Birthplace. ZELL MO 0  
(City, town, or county) (State or foreign country)

14. Maiden name. MARILENA OBERLE

15. Birthplace. ZELL MO 0  
(City, town, or county) (State or foreign country)

16. (a) Informant. Nancy Baechle  
(b) Address. St. Genevieve Mo

17. (a) BURIAL (b) Date thereof. AUG. 3-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. ZELL MO

18. (a) Signature of funeral director. J. C. Basher

(b) Address. St. Genevieve Mo

19. (a) July 31/44 (b) T. W. Douglas  
(Date of medical certifier) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JULY day 31  
year 1944 hour 3 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov. 6 1944  
to July 31 1944  
that I last saw her alive on July 31 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death. Admission of Thymoid  
Due to Neurasthenic colitis ?  
Toxic nephritis ?

Other conditions. 0  
(Include pregnancy within 3 months of death)

Major findings: 0  
Of operations. 0  
Of autopsy. 0

Duration ?  
? ?  
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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature. Rob Lanning (M. D. or other) 0  
Address. St. Genevieve Mo Date signed 8/31/44

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

95005

704

RECEIVED

District Health Officer No. 4  
District File Number 844-4161  
Date Filed 8-7-44

---

---

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 Geo. C. Barber

Licensed Embalmer No. 1985

P. O. Address St. Ignace 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, fact should be so stated above.**