

FILED AUG 2 1945

Registration District No. _____

Primary Registration District No. 5594

1. PLACE OF DEATH:

(a) County: JEFFERSON
(b) City or town: RURAL, TOWNSHIP Indiana
(c) Name of hospital or institution: Queen Home, Home Springs RR# 1
(d) Length of stay: In hospital or institution: Queen Home
In this community: Entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jefferson 50
(c) City or town: Home Springs Mo. RR# 1
(d) Street No. _____
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: EDWARD ANDREW OBER

3. (b) If veteran, name war: NONE
3. (c) Social Security No.: NONE

4. Sex: Male
5. Color: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bertha Ober nee oak
6. (c) Age of husband or wife if alive: 47 years
7. Birth date of deceased: Sept 21 1896
(Month) (Day) (Year)

8. AGE: Years 48 Months 9 Days 10
If less than one day hr. _____ min. _____

9. Birthplace: Home Springs RR# 1 Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Queen Farm

MOTHER FATHER
12. Name: Anton Ober
13. Birthplace: Home Springs RR# 1 Mo 0
14. Maiden name: Josephine Ober
15. Birthplace: High Ridge RR# 1 Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant: Bertha M Ober
(b) Address: Home Springs Mo RR# 1

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof: 7-5-1945
(c) Place: burial or cremation: Mt Hope Mausoleum de May Mo

18. (a) Signature of funeral director: J. H. Brummer
(b) Address: Home Springs - Mo

19. (a) 3 Jul 1945 (Date received local registrar)
(b) J. A. Townsend (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 3rd year: 1945 hour: 8:36 minute: 30th 8:36 A.M.
21. I hereby certify that I attended the deceased from June 30th to July 1st 1945
that I last saw him alive on July 1st 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis.
Due to: Atherosclerosis
Due to: Nephritis
Other conditions: (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? _____
(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: D. B. Edwards (M. D. or other)
Address: Cedar Hill Mo. Date signed: 7/2/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-1-45

AUG 7 1945

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 A. Bimmer

Licensed Embalmer No. 1479

P. O. Address House Springs

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.

Registration District No. 161

Primary Registration District No. 5594

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Royal Meramec City
(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..... years, months or days)

3. (a) PRINT FULL NAME Edward G. Ober

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 24 (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Day _____ If less than one day hr. _____ min. _____

9. Birthplace (City, town, or county) mo (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.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

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

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 13 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

(that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other condition Chronic Nephritis (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?.....

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

23. Signature E. B. Edwards (M.D. or other) P

Address Edwards Hill Date signed 8/13/48

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

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-24277