

FILED NOV 18 1945

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

In this community Otto Fechner
(years, months or days)

3. (a) PRINT FULL NAME Otto Fechner

3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-12-8554

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

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

7. Birth date of deceased August 15 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>79</u>	<u>2</u>	<u>20</u>		hr. _____ min. _____

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

10. Usual occupation Printer

11. Industry or business _____

12. Name Ernst Fechner Germany

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

14. Maiden name Unknown

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

16. (a) Informant Claude T. Fechner
Route 11 Box 126 Lemay Mo

(b) Address Burial Nov. 7 1945

17. (a) _____ (b) Date thereof Nov. 7 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem

18. (a) Signature of funeral director Thos. Kuter, Son

(b) Address 2906 Gravois

19. (a) NOV 6 1945 (b) J. H. Redden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3332 A Vista
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5
year 1945 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 17 1945 to Nov 5 1945
that I last saw him alive on Nov 4 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of gall bladder + liver

Due to _____

Due to Primary in liver

Other conditions HT 7
(Include pregnancy within 3 months of death)

Major findings: Carcinoma (liver) + gall bladder

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 Edmond G. must (M. D. or other) _____

Address 1504 So Grand Date signed 11-7-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *David J. Brown*

Licensed Embalmer No. *42*

P. O. Address *2906*

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.