

No. 2
5-43
5-17-39
I X36671

Registration District No. **318** Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5448 Loughborough
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **60 yrs.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5448 Loughborough**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Alois Ochmann**

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 **widower**
6. (b) Name of husband or wife **Marie** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 21 1858**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 8 13 hr. min.

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

10. Usual occupation **Retired coal miner**

11. Industry or business _____

MOTHER FATHER

12. Name **not known**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **not known**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Martin Holch**
(b) Address **5448 Loughborough**
17. (a) **Burial** (Burial, entombment, or removal) (b) Date thereof **3-6-46**
(Month) (Day) (Year)
(c) Place: burial or cremation **Sesser, Ill.**
18. (a) Signature of funeral director **J. L. Ziegenhein & Sons**
(b) Address **7027 Gravois Ave.**
19. (a) **MAR 5 1946** (Date received by Registrar) **J. F. Brudeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **4**
year **1946** hour **5** minute **30** p. a. m.

21. I hereby certify that I attended the deceased from **2-27-1946**, 19____, to **Mar, 2-1946**, 19____;
that I last saw him alive on **Mar, 2-1946**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Senility
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury _____
23. Signature **Chas. J. ...** (M. D. or other) _____
Address **25912 S. Kingsway** Date signed **3-5-46**

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

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *7027 Travis*

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. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St Louis
(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 Alois Ochmann

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 wid

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

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

8. AGE: Years 87 Months Days 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..... (City, town, or county) (State or foreign country)

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 CERTIFICATE (FO)

20. DATE OF DEATH: Month March year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death..... Duration

Senility
Intestinal Autointoxication

Due to.....
Due to.....

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

Major findings:
Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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 St. Louis (M. D. or other) 1234
Address 5912 S. Washington Date signed 3-22-46

1041 WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

