

No. 2
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-5-17-39
TX47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10807**
3482
Registrar's No.

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:
DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 weeks**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Frank H. Fechtler**

3. (b) If veteran, name war **X** 3. (c) Social Security No. **493-10-6424**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Georgia Fechtler** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Sept. 9, 1879**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	6	22	hr. min.

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

10. Usual occupation **retired butcher & grocer**

11. Industry or business _____

12. Name **Henry Fechtler**

13. Birthplace **Buford Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Stuhaln**

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

16. (a) Informant **Georgia Fechtler**

(b) Address **4518a Arsenal**

17. (c) **Burial** (b) Date thereof **4/2/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn Cemetery**

18. (a) Signature of funeral director **John L Ziegenhein & Sons**

(b) Address **7027 Gravois**

19. (a) **APR 2 1947** (b) **J. F. Budrich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **san**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4518a Arsenal St**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31** year **1947** hour **8** minute **25** P.M.

21. I hereby certify that I attended the deceased from **Feb 1st** to **March 31**, 19**47**
that I last saw him alive on **March 30**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Heart Disease
Due to _____
Due to _____

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

Major findings:
Of operations **PH**
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? _____

23. Signature **M. J. Juran** (Specify type of place) _____ (M. D. or other)
Address **St. Louis, Mo.** (e) Means of injury _____
Date signed **4/1/47**

Duration
6 mo
PH
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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed W. G. Peterson
Licensed Embalmer No. 3767
P. O. Address 7027 Gravois

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 3482

Registration District No. 218 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) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Frank H. Fechte

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 9 (Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ (If less than one day hr. min.)

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

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) 4-2-1947 (Date received local registrar) (b) J. F. Brueck (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 April 1947 year. _____ hour _____ minute _____ M.

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

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? _____

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

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

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

SUPPLEMENTARY

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

APR 21 1947

10807