

1. PLACE OF DEATH:

(a) County ST. CHARLES
(b) City or town O'FALLON
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. CHARLES
(c) City or town O'FALLON
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME

HENRY OBRECHT

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

4. Sex MC 5. Color or race W 6. (a) Single, widowed, married, divorced — / —

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

7. Birth date of deceased APRIL (Month) 7 (Day) 1869 (Year)

8. AGE: Years 78 Months 9 Days 8 If less than one day — hr. — min.

9. Birthplace ST. CHARLES Co MO (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business —

12. Name NOT KNOWN

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 MRS. ANNA OBRECHT

(b) Address O'FALLON MO

17. (a) J (b) Date thereof 1 19 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O'FALLON MO

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

(b) Address O'FALLON MO

19. (a) Jan 19 48 (b) E. Keithley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 15 year 1948 hour 12 minute — M.

21. I hereby certify that I attended the deceased from Jan 1947, to Jan 15 1948; that I last saw him alive on 14 Jan 1948 and that death occurred on the date and hour stated above.

Immediate cause of death uremia
Due to chronic glomerular nephritis 2 yrs
Due to generalized arteriosclerosis 10 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations B
Of autopsy B

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? 0

(Specify type of place) (Specify means of injury)
While at work —
23. Signature Lawrence B Behan MD (M. D. or other)
Address O'Fallon Mo. Date signed 1-17-48

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

12
0
0

92
0
0

Duration 2 wks

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

RECEIVED
District Health Officer, No. 9,
District File Number
Date Filed 1/23/08

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 E. Keenly
Licensed Embalmer No. 822
P. O. Address O'FALLON 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.