

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26320**
Registrar's No. **6343**

FILED JUL 31 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospt		e. STREET ADDRESS (If rural, give location) 17 2354 Klemm St 2179			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) H. c. (Last) Fechtel			4. DATE OF DEATH (Month) (Day) (Year) June 25 1953		
----------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--	--

5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug 12 1874		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
--------------------	--	-------------------------------	--	-----------------------------------------------------------------------	--	-------------------------------------	--	-------------------------------------------	--	-------------------------	--	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker			10b. KIND OF BUSINESS OR INDUSTRY Office of Priest			11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.		
------------------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--	--	-------------------------------------------------------------------------	--	--	------------------------------------------	--	--

13a. FATHER'S NAME Herman Fechtel			13b. MOTHER'S MAIDEN NAME Agnes Risse			14. NAME OF HUSBAND OR WIFE Hilda, Lanier, Fechtel					
------------------------------------------	--	--	----------------------------------------------	--	--	-----------------------------------------------------------	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Hilda Fechtel ADDRESS 2354 Klemm							
-----------------------------------------------------------------------------	--	-------------------------------------	--	----------------------------------------------------------------------------------	--	--	--	--	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate									
		ANTECEDENT CAUSES		DUE TO (b) _____							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									

19a. DATE OF OPERATION 4-23-46		19b. MAJOR FINDINGS OF OPERATION Carcinoma of prostate								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
---------------------------------------	--	---------------------------------------------------------------	--	--	--	--	--	--	--	----------------------------------------------------------------------------------	--

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) 53		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
------------------------------------------------------	--	------------------------------------------------------------------------------------------	--	-------------------------------------------------	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? 177X		
-------------------------------------------------	--	--	--------------------------------------------------------------------------------------------------------	--	--	----------------------------------------	--	--

22. I hereby certify that I attended the deceased from **4-8 1946** to **6-23 1953**, that I last saw the deceased alive on **6/24 1953**, and that death occurred at **5.15 P.M.** from the causes and on the date stated above.

23a. SIGNATURE W. F. Melick M.D. (Degree or title)		23b. ADDRESS 539 N. Grand Ave		23c. DATE SIGNED 6-25-53	
-----------------------------------------------------------	--	--------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 27 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
---------------------------------------------------------	--	-------------------------------	--	------------------------------------------------------------	--	--------------------------------------------------------------------	--

DATE REC'D BY LOCAL REG. JUN 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Weifk Bros ADDRESS 2201 S. Grand Blvd	
---------------------------------------------	--	--------------------------------------------------	--	--------------------------------------------------------------------------------------	--

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

Dr. Wm F. Mellick
2554
539 N. Grand
Lin 6396

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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. Allen Rawing*.....
Licensed Embalmer No. *4057*.....
P. O. Address *H. L.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.