

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011252  
STATE FILE NUMBER  
3170

FILED APR 10 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>		d. STREET ADDRESS (If outside, give location) <b>4904 McPherson Ave.</b>	

3. NAME OF DECEASED (Type or print) First <b>LENORE</b> Middle <b>OBERMOELLER</b> Last		4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>59</b>	
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1897</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Charles W. Obermoeller</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Crain</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. Mark Obermoeller, 1004 N. Taylor Ave.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>fatal cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>cerebral vascular arteriosclerosis</b>	
	DUE TO (c) <b>hypertensive cardio vascular disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Status convulsus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>443X</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Missouri</b>
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21. I attended the deceased from <b>3-28-59</b> to <b>3-28-59</b> and last saw her/him alive on <b>3-28-59</b> Death occurred at <b>5:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Mary O. Moran, M.D.</b>	22b. ADDRESS <b>1515 LA FAYETTE AVE</b>	22c. DATE SIGNED <b>3-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 31, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 30 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57  
94  
6

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 *W. S. Loper* .....

Licensed Embalmer No. *4699* .....  
P. O. Address *3840 Lunde* .....

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.