

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REG'D SEP 7 1939
Registration District No. 704

Primary Registration District No. 210

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Edgewood Nursing Home.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 1
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 4476 Washington Blv'd,
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Otto Wade Fallert. 463

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

4. Sex Male. 5. Color or race White.
6. (a) Single, widowed, married, divorced Single.
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March, 31, 1879.
(Month) (Day) (Year)

8. AGE: Years 60. Months 5. Days 0.
If less than one day
hr. _____ min.

9. Birthplace Unknown. Vermont.
(City, town, or county) (State or foreign country)

10. Usual occupation Professor of Music.
Voice, piano Organ.

11. Industry or business _____
MOTHER FATHER { 12. Name Albert Fallert.
13. Birthplace Unknown. Vermont.
(City, town, or county) (State or foreign country)
14. Maiden name Jennie Wade.
15. Birthplace Unknown. Vermont.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature O. J. Fairer.
(b) Address 4476 Washington Blv'd.

17. (a) Burial. (b) Date thereof 9/2/39.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director C. R. Lupton & Sons.
(b) Address 7233 Delmar Blv'd.

19. (a) SEP - 2 1939 (b) C. R. Lupton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8-31 day 1939
year 1939 hour 9:5 P minute _____ M.
21. I hereby certify that I attended the deceased from 6-30-39
_____, 19____, to 8-31, 19____;
that I last saw him alive on 8-31, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchia pneumonia Duration 2da
Streptococcus type
Due to Streptococcus throat 2 wks
Due to Infected teeth 1 yr

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no 1/5:0
Of autopsy no
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 C. R. Lupton (M. D. or other) _____
Address 340 Delmar Date signed 9-1-39

723
0767 23

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.....

Don Muschany, Registered Apprentice No. # 219
working under my personal supervision.

Signed Bradford A. Miles
Licensed Embalmer No. 2901
P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.