S. No. 2
M—2-43
5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 8 1945

Registration District No. 3306

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6048

State File No. 14421

Registrar's No. 237

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town O'Fallon Dadrant
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Charles

(c) City or town O'Fallon 99
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? --------- 0 (Yes or No)

If yes, name country ---------

3. (a) PRINT FULL NAME Ida C. Gentemann

3. (b) If veteran, name war -------

3. (c) Social Security No. --------

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife F.H.Gentemann Deceased

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

7. Birth date of deceased November (Month) 5 (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
75	5	18	hr. min.

9. Birthplace St. Paul Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business --------

FATHER
12. Name Fred Grabenhorst
13. Birthplace Prussia (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Dyer
15. Birthplace St. Paul Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant Geo. Grabenhorst
(b) Address O'Fallon Mo. R2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul Mo.

18. (a) Signature of funeral director E.A. Keithly
(b) Address O'Fallon Mo.

19. (a) April 24-45 (Date received local registrar) (b) E.A. Keithly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April, day 23, year 1945 hour minute M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Cerebral Hemorrhage

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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?
(Specify type of place)
While at work? (e) Means of injury 3

23. Signature Marie Murphy Coroner
Address Wentzville, Mo Date signed 3/23/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-7-45

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. A. Keithly

Licensed Embalmer No. 8 rr

P. O. Address Fulton 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.