

S. No. M-5-43 5-17-39 I X36671

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

State File No. 39130 Registrar's No. 11099

FILED JAN 5 1946 318

STANDARD CERTIFICATE OF DEATH 1003

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis (b) City or town St. Louis (c) Name of hospital or institution: 1250a Hodiamont Ave. (d) Length of stay: In hospital or institution. (Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Theodore J. Fechtman.

3. (b) If veteran, name war #2 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cecilia Fechtman 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased July 2, 1897. (Month) (Day) (Year)

Table with columns: AGE: Years (48), Months (5), Days (17), If less than one day (hr., min.)

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

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER

12. Name Theodore Fechtman

13. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

14. Maiden name Margaret Hagner

15. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Kehoe

(b) Address 1250A Hodiamont Ave.,

17. (a) Burial (b) Date thereof Dec. 22/45. (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. National Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.,

19. (a) DEC 19 1945 (b) J. Medich (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis (c) City or town St. Louis (d) Street No. 1250A Hodiamont Ave. (e) Citizen of foreign country? (Yes or No) If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19 year 1945 hour 6 minutes 45 M.

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

Immediate cause of death: Disruption of blood vessel in the brain... (Handwritten medical notes)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions (Include pregnancy within 3 months)

Major findings: Of operations

Of autopsy

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 (b) Date of occurrence Dec 19 1945 (c) Where did injury occur? (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 (M. D. or other) Address Date signed

City Coroner Office

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.....

Alfred J. Boedeker
.....
Licensed Embalmer No. 2663

P. O. Address..... 1125 Hodiament Ave.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318Primary Registration District No. 1003Registrar's No. 11099

1. PLACE OF DEATH:

- (a) County St. Louis
 (b) City or town St. Louis
 (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)3. (a) PRINT FULL NAME Theodore J. Fechtman3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased July 2, 1900
(Month) (Day) (Year)8. AGE: Years 48 Months _____ Days _____ If less than one day
_____ hr. _____ min.9. Birthplace Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 1948
year 1948 hour _____ minute 45 A.M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Skullfracture of skull and subarachnoid hemorrhage of brain when he was found at thefront of 24 Wacker St. in hishome 1250' Hickman AveDue around 6:45 to 6:50 AM Dec 19, 1948Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental(b) Date of occurrence Dec 19, 1948(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
NoneWhile at work? _____ (Specify type of place)
(e) Means of injury as above23. Signature Patrick E. Sigafoos, M.D. (M. D. or other)Address _____ Date signed 1/14/49

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

SUPPLEMENTARY

39130