

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 22 1957

BIRTH NO. _____		REG. DIST. NO. <u>306</u>		PRIMARY REG. DIST. NO. <u>6048</u>		Registrar's No. <u>11</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE <u>Mo</u> b. COUNTY <u>ST. CHARLES</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'FALLON</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>O'FALLON</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS <u>0920</u> (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) _____		c. (Last) <u>OBRECHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 12-1957</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED <u>2</u>		8. DATE OF BIRTH <u>MAY 16-1874</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State Foreign Country) <u>ST. PETERS Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>FRANK SCHWENDEMANN</u>		13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>HY. OBRECHT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do, or no) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>PAUL OBRECHT</u>		ADDRESS <u>O'FALLON Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>491X</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1957, to <u>April 12</u> , 1957, that I last saw the deceased alive on <u>April 12</u> , 1957, and that death occurred at <u>10:50 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Harold O. Mangos D.O. 2</u>				23b. ADDRESS <u>O'Fallon Mo</u>		23c. DATE SIGNED <u>4-13-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>APRIL 15-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ASSUMPTION</u>		24d. LOCATION (City, town, or county) (State) <u>O'FALLON Mo</u>	
DATE REC'D BY LOCAL REG. <u>April 14 '57</u>		REGISTRAR'S SIGNATURE <u>Ed Keithly</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ed Keithly O'Fallon Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....  
*E. Keithly*

Licensed Embalmer No. *822*

P. O. Address *Fallon W*

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.