

FILED JUN 9 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4916**

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:
City Infirmary 0 1/2 plus
(If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community..... 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 713
 (d) Street No. 5800 Arsenal St.
(If rural, give location)
 (e) Citizen of foreign country? American (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME

Henry Osler

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

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

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased June 2, 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>70</u>	<u>11</u>	<u>18</u> hr. min.

9. Birthplace Kokomo, Ind
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Abraham Osler

13. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Lucinda Fearson

15. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant C. Hannon

(b) Address 5800 Arsenal St.

17. (a) Anatomical Board (b) Date thereof 5-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wendover

18. (a) Signature of funeral director W. K. [Signature]

(b) Address 3100 [Address]

19. (a) MAY 29 1944 J. F. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
 year 1944 hour 11:00 a. minute 00 M.

21. I hereby certify that I attended the deceased from.....
 19..... to May 20, 1944, 19.....;
 that I last saw him alive on May 20, 1944, 19.....;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
due to atherosclerosis
 Due to.....
 Other conditions Syphilis, tabes dorsalis, Aneurysm
(Include pregnancy within 3 months of death)
 Major findings: 30
 Of operations.....
 Of autopsy To Anatomical Board

Duration

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 Doner & [Signature] M.D.
 Address 5800 Arsenal St Date signed 5-24-44

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

JUN 10

Registration District No. 368 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(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

Henry Oster

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased June 2 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days _____ (If less than one day, _____ min.)

9. Birthplace _____ (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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JUN 12 1944 (b) J. F. Bruesch (Date recorded and certified by) (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 May 1944 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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 (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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTAL

FILED

16625