

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

1. PLACE OF DEATH:  
(a) County Jefferson  
(b) City or town Rural, Mercersville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph's Hill Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 yrs 8 mos  
In this community 2 yrs 8 mos (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jefferson  
(c) City or town Rural 50  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Joseph's Hill Infirmary  
(If rural, give location)  
(e) Citizen of foreign country? do not know (Yes or No)  
If yes, name country Switzerland

3. (a) PRINT FULL NAME William Postman  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 10  
year 1945 hour 5:55 P. minute M.

4. Sex male 5. Color or race White  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Olga  
6. (c) Age of husband or wife if alive 18 years  
7. Birth date of deceased Aug. 24 1857  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 2- 1944, to January 10 1945;  
that I last saw him alive on Jan 10 1945,  
and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months 4 Days 18  
If less than one day hr. min.

Immediate cause of death chronic myocarditis years  
Duration

9. Birthplace Switzerland 5  
(City, town, or county) (State or foreign country)  
10. Usual occupation gardner retired  
11. Industry or business as above

Due to —  
Due to — 9 3/4  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations —  
Of autopsy —

MOTHER FATHER  
12. Name —  
13. Birthplace (City, town, or county) (State or foreign country) 9  
14. Maiden name —  
15. Birthplace (City, town, or county) (State or foreign country) 9

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Brother Spluid B. 58  
(b) Address St. Joseph's Hill Church  
17. (a) Removal (b) Date thereof 1-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Paul's Ev. Cemetery  
18. (a) Signature of funeral director Blumstein Bros  
(b) Address 2504 Woodson St - Overland, Mo.  
19. (a) Jan 1945 (b) J. L. Torrie  
(Date received local registrar) (Registrar's signature)

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 John L. Meader (M. D. or other) C  
Address 3155 N. Vandeventer Date signed 1/13/45

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 3-5-45

**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 Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 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.**