

FILED MAY 21 1945

Registration District No. 818

Primary Registration District No. 1003

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

20
17
9

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1. ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Herman Ostman

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 Married

6. (b) Name of husband or wife Margaret Ostman 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 29, 1877
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | <u>67</u> | <u>11</u> | <u>12</u> | hr. _____ min. |

9. Birthplace Germany //
(City, town, or county) (State or foreign country)

10. Usual occupation Circular Distributor //

11. Industry or business _____

12. Name August Ostman

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

14. Maiden name Wilhelmina Hamka

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

16. (a) Informant Margaret Ostman

(b) Address 2204 S. 4th Street

17. (a) Burial (b) Date thereof May 14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl.

19. (a) MAY 12 1945 (b) J. F. Bredich
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2204 S. 4th Street
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th
year 1945 hour 11:35 minute A. M.

21. I hereby certify that I attended the deceased from 5/7/45
to 5/11/45, 19____, to 5/11/45, 19____;
that I last saw h. im alive on 5/11/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Same

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) _____
Meaning injury? _____

23. Signature James J. Hunt (M. D. or other) _____
Address 195 Lafayette 5/11/45 Date signed

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 *Harry A. Stewart*.....

Licensed Embalmer No. **3722**.....

P. O. Address **412 Duchouquette St.**.....

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.