

7. S. No. 2  
FORM-2-43  
rev. 5-17-39

#49302

19089

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

State File No. \_\_\_\_\_  
Registrar's No. 5632

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, Mo.

(b) City or town St. Louis, Mo.  
(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 2 days  
(Specify whether years, months or days)

In this community unk.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 061

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

(d) Street No. 1314 Buchanan  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LENA OSTERMAN

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced, single

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

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

7. Birth date of deceased November 7th, ?  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>abt - 75</u>			hr. _____ min.

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

10. Usual occupation unk

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name unk.

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

14. Maiden name unk.

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

16. (a) Informant M. A. Renard

(b) Address St. Louis City Hospital #1

17. (a) Anatomical Board (b) Date of burial or cremation 6-27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. R. Kutzner

18. (a) Signature of funeral director W. R. Kutzner

(b) Address St. J. & Kutzner Dr.

19. (a) JUN 28 1945 (b) Registrar's signature J. J. Renard  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23rd  
year 1945 hour 5:15 minute A. M.

21. I hereby certify that I attended the deceased from 6/21/45  
\_\_\_\_\_ 19, to 6/23/45 \_\_\_\_\_ 19;  
that I last saw her alive on 6/23/45 \_\_\_\_\_ 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Starvation - Incontinence Deprivation of water

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 1869  
(Include pregnancy within 3 months of death)

Major findings: 19  
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 0

23. Signature Robert Herdlin (M. D. or \_\_\_\_\_)  
Address 1515 Lafayette Date signed 6/23/45

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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.....  
....., 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.**