

No. 2
-12-45
-5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38205

State File No.

FILED DEC 30, 1946

Registration District No.

Primary Registration District No.

6076

Registrar's No.

3342

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 11-9-46
(Specify whether years, months or days)
In this community 50 years

3. (a) PRINT FULL NAME BIRKMANN, Oscar Fred
3. (b) If veteran, name war World I
3. (c) Social Security No. None

4. Sex Male 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 Dec. 17, 1893
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 5
If less than one day _____ hr. _____ min.

9. Birthplace: New Haven, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

11. Industry or business
12. Name William Birkmann
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Anna Windhorst
15. Birthplace Gasconade County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar, Vet. Adm. Hosp.
(b) Address Jefferson Barracks, Missouri
17. (a) Burial (b) Date thereof 11-25-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Beaufort, Mo.

18. (a) Signature of funeral director Albert H. Hoppel
(b) Address Service 4700 Washington Blvd.
19. (a) 11-25-46 (b) Paul H. Hoppel
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town S. Beaufort
(If outside city or town limits, write "RURAL")
(d) Street No. R.R.#1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
year 1946 hour 8:45 A.M. minute _____ M.
21. I hereby certify that I attended the deceased from November
9, 19 46 to November 22, 19 46;
that I last saw him alive on November 22, 19 46;
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCLUSION Duration UNK.

Due to _____
Due to _____

Other conditions: CORONARY ARTERIOSCLEROSIS UNK.
(Include pregnancy within 3 months of death)

Major findings: No Operation
Of operations _____
Of autopsy No Autopsy
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) No
(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? _____ Mean of injury _____
23. Signature L. E. Stilwell (Specify type of place) (M. D. or other)
L. E. Stilwell
Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 11-22-46

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

MOTHER FATHER

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.....

J. W. Wilkins

Licensed Embalmer No.....

3575

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.