

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 28100  
 7478

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1005		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois. b. COUNTY 947			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis (1)		c. LENGTH OF STAY (in this place) 1 DAY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Duquoin 11		d. STREET ADDRESS (If rural, give location) R.R. 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital							
3. NAME OF DECEASED (Type or Print) a. (First) Bennett b. (Middle) Jo c. (Last) Oestreicher			4. DATE OF DEATH (Month) (Day) (Year) 8 25 1949				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8-24-49	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis mo		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Russel R Oestreicher		13b. MOTHER'S MAIDEN NAME Marnie O Peters		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Russel R Oestreicher Duquoin 28			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Erythroblastosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 day	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 161 c			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 77 M			
22. I hereby certify that I attended the deceased from 8/24 1949 to 8/25 1949, that I last saw the deceased alive on 8/24 1949, and that death occurred at 11:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. B. Basaler M.D.				23b. ADDRESS 4952 Mayfield		23c. DATE SIGNED 8/24/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-26-49		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Duquoin Illinois	
DATE REC'D BY LOCAL REG. AUG 29 1949				REGISTRAR'S SIGNATURE J. B. Basaler		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc.	

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

7478

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Ronald O Kahne

Licensed Embalmer No. 3917

P. O. Address St. Louis

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.