

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2867

#106858

2009

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 687

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY <del>ST LOUIS</del>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
c. LENGTH OF STAY (In this place) 3 WKS		d. STREET ADDRESS (If rural, give location) 1830 RUSSELL BLVD	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			

3. NAME OF DECEASED (Type or Print) a. (First) CAROLINE b. (Middle) OELZEN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan. 21st, 1950		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 1 1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 8 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME HENRY JUSTEN	13b. MOTHER'S MAIDEN NAME CAROLINA DIECKMANN	14. NAME OF HUSBAND OR WIFE WILLIAM OELZEN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Oelzen	ADDRESS 1830 RUSSELL BLVD ST LOUIS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral thrombosis (left)		INTERVAL BETWEEN ONSET AND DEATH 20 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cerebral arteriosclerosis		
	DUE TO (c) Hypertensive Cardiovascular disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 332X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 12/30/49, 19, to 1/21/50, 19, that I last saw the deceased alive on 1/21/50, 19, and that death occurred at 5:20am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gloria Taylor M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 1/21/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE JAN 23, 1950	24c. NAME OF CEMETERY OR CREMATORY WATERLOO	24d. LOCATION (City, town, or county) (State) WATERLOO ILLINOIS
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DATE REC'D BY LOCAL REG. JAN 23 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE Emil Luemheim	ADDRESS WATERLOO ILL.
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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 me

working under my personal supervision.

Student Embalmer No.....

Signed Ben. H. Baldern

Signed.....  
Student Embalmer

Licensed Embalmer No. 2420

P. O. Address E. St Louis Ills

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.