

THE DIVISION OF HEALTH OF MISSOURI
FILED JUL 22 1950 STANDARD CERTIFICATE OF DEATH

25134
State File No. 6084
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place) Years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3842 Missouri Ave		24 STREET ADDRESS (If rural, give location) 3842 Missouri.	

3. NAME OF DECEASED (Type or Print) a. (First) AMELIA b. (Middle) M. c. (Last) OSMAN			4. DATE OF DEATH (Month) (Day) (Year) July 13, 1950		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 25, 1860	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At. Home		11. BIRTHPLACE (State or foreign country) Johnsonville, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME J.W.K. Jackson		13b. MOTHER'S MAIDEN NAME Mary Russian		14. NAME OF HUSBAND OR WIFE William			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mamie Baker, 3842 Missouri, St. Louis, Mo.					
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		Arterio-Sclerosis				Several weeks	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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 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)	
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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? 4500		
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22. I hereby certify that I attended the deceased from July 8, 1950, to July 13, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. E. Resutoff MD		23b. ADDRESS 3612 S. Jefferson Ave		23c. DATE SIGNED 7-14-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/17/1950	24c. NAME OF CEMETERY OR CREMATORY St. John's	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
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DATE REC'D BY LOCAL REG. JUL 14 1950	REGISTRAR'S SIGNATURE J. P. Katcher		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin Funeral Home, 2301 Lafayette		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Lewis Resnikoff
3407 A. So. Jefferson

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed..... *James R. Chapman*

Licensed Embalmer No. *4550*

P. O. Address. *St. Louis, Mo.*

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.