

No. 300  
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REG# 105930

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# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **37284**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2792**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS COUNTY Baden 40/0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>10187 TOELLE LANE</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>HENRY</b>	b. (Middle) <b>A.</b>	c. (Last) <b>OSTMANN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10-29-52</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-1-72</b>	9. AGE (In years last birthday) <b>80</b>	10. MONTHS <b>1</b>	11. DAYS <b>10</b>	12. HOURS <b>10</b>	13. MIN. <b>05</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>HANOVER, GERMANY</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>AUGUST OSTMANN</b>	13b. MOTHER'S MAIDEN NAME <b>AMELIA POLSON</b>	14. NAME OF HUSBAND OR WIFE <b>KATHERINE OSTMANN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	16. SOCIAL SECURITY NO. (If year of year or dates of service) <b>SPAW</b>	17. INFORMANT'S SIGNATURE OR NAME <b>VA HOSPITAL RECORDS, JEFF BRKS, MO.</b>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL ENCEPHALOMALACIA</b>		DUE TO (b) <b>CEREBRAL THROMBOSIS</b>		<b>Unk.</b>
ANTECEDENT CAUSES		DUE TO (c) <b>-</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>332X</b>		<b>Appr. 10 das.</b>

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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) <b>VA</b>	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 **10-20-52**, 19**52**, to **10-29-52**, and that death occurred at **5:55P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph P. Kamzyskas</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>VET ADM HOSP, JEFF BRKS, MO.</b>	23c. DATE SIGNED <b>10-29-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>11/3/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS, MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>10-30-52</b>	REGISTRAR'S SIGNATURE <b>Hubert R. Daniels-MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Diedrich F. Home</b>	ADDRESS <b>8319 Hallsferry</b>
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P.T. (Licensed Embalmer's Statement on Reverse Side)

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

1000

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 Eleus Province

Licensed Embalmer No. 3403

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.