

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16073
State File No.

FILED MAY 14 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 4063

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		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3530 Arkansas		e. STREET ADDRESS (If rural, give location) 16 3530 Arkansas 2169	
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) F. c. (Last) Oswald		4. DATE OF DEATH (Month) (Day) (Year) April 17 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 24, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (in years last birthday) 85
11. BIRTHPLACE (City and State or Foreign Country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Amelia		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. ---		17. INFORMANT'S SIGNATURE OR NAME Carl H. Oswald ADDRESS 3834 Minnesota Ave.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of right temple, hemorrhage, self inflicted at his home death 4:00 pm April 17 1953 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS While suffering temporary mental aberration	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Suicide	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) Suicide	
21b. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Apr 17 53 4:00 pm		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? E976X		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P. M., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Patrick J. Taylor Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED APR 18 1953		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Apr. 20, 1953		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Carl Smith 3634 Gravois Ave.	

WRITE PLAINLY—USING UNFADING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Robert C Wheeler

Licensed Embalmer No.....
2128

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.