

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12998

State File No.

FILED APR 26 1955

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 99

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>St. Charles</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
• STREET ADDRESS		(If rural, give location) <u>409 N. 6th St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>IDA</u>	b. (Middle)	c. (Last) <u>OSIEK</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>April 17, 1955</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 17, 1883</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Days <u>0</u> Hours <u>0</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Carl Bull</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Weber</u>	14. NAME OF HUSBAND OR WIFE <u>William Osiek</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>William Osiek, St. Charles, Mo.</u>	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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	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. <u>Bronchopneumonia</u>		<u>3 days</u>

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? <u>332 X</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from April 11, 1955, to April 17, 1955, that I last saw the deceased alive on April 17, 1955, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Don Z. Randall, M.D.</u>	23b. ADDRESS <u>207 N. 5th St. Charles, Mo.</u>	23c. DATE SIGNED <u>April 19, 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 20, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>April 20 1955</u>	REGISTRAR'S SIGNATURE <u>Franie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Baw.</u>	ADDRESS <u>St. Charles, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Clarence M. Billie*

Licensed Embalmer No. *4375*

P. O. Address *St. Charles*

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.