

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **28929**  
**6642**

FILED AUG 24 1956

**318**

**1003**

Registration District No. .... Primary Registration District No. .... Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>Centralia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <u>Chris Henry Oestreich</u>		4. DATE OF DEATH <i>Month Day Year</i> <u>July 13, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-18822</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal mine</u>	9. AGE (In years last birthday) <u>74</u>
11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>Carl Oestreich</u>		14. MOTHER'S MAIDEN NAME <u>Charolette Duntelon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Robert Oestreich, Centralia, Ill.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pyriform sinus</u> <u>With metastases</u> DUE TO (b) _____ DUE TO (c) <u>147, X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <i>Hour a. m. p. m.</i> Month, Day, Year		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>July 3, 1956</u> to <u>July 13, 1956</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>July 13, 1956</u> Death occurred at <u>4:20 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>FR Bradley</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>7/13/56</u>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>7-13-56</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Centralia, Ill.</u>	
24. FUNERAL DIRECTOR <u>Queen-Boggs, Centralia, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 16 1956</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MS</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

---

---

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.....  
*Frank Proff*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.