

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **38518**
REGISTRAR'S NO. **2352**

Registration District No. **317** Primary Registration District No. **542**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ferguson		c. CITY OR TOWN Ferguson 40090	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 361 Rand Drive		d. STREET ADDRESS (If outside, give location) 361 Rand Drive	
3. NAME OF DECEASED (Type or print) First Joseph Middle — Last Oswald, Sr.		4. DATE OF DEATH Month 9 Day 21 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-1880
10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) Heat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Austria
13a. FATHER'S NAME Oswald		13b. MOTHER'S MAIDEN NAME Fciertag	14. NAME OF HUSBAND OR WIFE Anna Oswald
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 488-05-9479	17. INFORMANT Address Anna Oswald - 361 Rand Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Arterio Sclerotic Heart Disease DUE TO (c) 10 yrs. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 .Hour Month, Day, Year a.m. p.m.			
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 1955 to 9-21-57 and last saw him alive on 9-21-57 Death occurred at 10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. J. Homich (Degree or title) MD		22b. ADDRESS 8902 Riverview Blvd	22c. DATE SIGNED 9-23-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-24-1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or country) (State) St. Louis Mo
24. FUNERAL DIRECTOR ADDRESS Edw Koch + Son - 3516 N. 14th		25. DATE RECD. BY LOCAL REG. 9-23-57	26. REGISTRAR'S SIGNATURE Herbert R. Donche MD

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

asc

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 *Dustan W. Smith*

Licensed Embalmer No. *4329*
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.