

Health,  
& Welfare  
Public  
Service

XC #755860  
R# 120675

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024183  
STATE FILE NUMBER

Registration District No. **317** Primary Registration District No. **500** Registrar's No. **1683**

FILED JUL 11 1958

300  
1-57

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>Washington</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson Barracks</b>		c. CITY OR TOWN <b>Cadet 11000</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Veterans Adm. Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>None</b>	
Length of stay in 1b <b>32 days</b>		Reside on Farm <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>W.</b> Last <b>OSIA</b>			4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1887</b>	9. AGE (In years last birthday) <b>60</b>	FUNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</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 country) <b>Old Mines, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>ZENO OSIA</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>ROSE BELL OSIA</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Address <b>VA Hospital Records, Jefferson Barracks, Mo</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ENCEPHALOMALACIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>	<b>2 years</b>
	DUE TO (c) <b>GENERAL ARTERIOSCLEROSIS</b>	<b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		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.)
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20c. TIME OF INJURY Hour <b>5:35</b> Month <b>June</b> Day <b>23</b> Year <b>1958</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>VAH Jefferson Barracks, Mo.</b>	COUNTY <b>Mo.</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>April 22, 1958</b> to <b>June 23, 1958</b> Death occurred at <b>June 23, 1958 5:35</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>W. Oppler, Dir. Prof. Services MD</b>	22b. ADDRESS <b>VAH Jefferson Barracks, Mo.</b>	22c. DATE SIGNED <b>6-23-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/26/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joachims</b>	23d. LOCATION (City, town, or county) (State) <b>Oldmines Mo.</b>
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24. FUNERAL DIRECTOR <b>Arthur W. Smith</b>	ADDRESS <b>Potosi Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6/24/58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Dombek</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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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  .....

Licensed Embalmer No. 4104  
P. O. Address DeLoach, 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.