

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020013  
STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1330

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Velda Village</u>                 |  | c. CITY <u>4000</u><br>OR TOWN <u>Velda Village</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Enroute to Hospital</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>3101 Kemp Avenue.</u>  |  |

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED<br>(Type or print) <u>ALEXANDER (ALEX) P. OSTROW</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>14th</u> Year <u>1959</u> |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 21, 1894</u>                               | 9. AGE (In years last birthday) <u>64</u><br>IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Assembler</u>                |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Star Coffee Co.</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Poland</u>           |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13. FATHER'S NAME<br><u>Peter Ostrow</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                            |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no none</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>399-07-5913</u>   | 17. INFORMANT Address<br><u>Mrs. Mary Ostrow 3101 Kemp Ave.</u>       |   |   |

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|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown Natural Causes</u> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____                           |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>7954</u>                |  | 19. WAS AUTOPSY PERFORMED? <u>0</u><br>YES <input type="checkbox"/> NO <input 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<br>Hour _____ 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at 6:44 m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |  |                              |
|---|--|------------------------------|
| 22a. SIGNATURE (Type or print)<br><u>John C. Murphy MD Acting Health Commissioner</u> | 22b. ADDRESS<br><u>801 S. Brentwood Clayton, Mo.</u> | 22c. DATE SIGNED<br><u>5</u> |
|---|--|------------------------------|

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>                         | 23b. DATE<br><u>May 15, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LOCAL</u> | 23d. LOCATION (City, town, or county) (State)<br><u>CHICAGO, ILL.</u> |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>JOHN STYGAR &amp; SON - 554I RIVERVIEW BLVD,</u> |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>5-14-59</u>     | 26. REGISTRAR'S SIGNATURE<br><u>John C. Murphy MD</u>                 |

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service  
 300  
 5-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. 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

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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. 390

P. O. Address A. L. ...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.