

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020377  
STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. \_\_\_\_\_ Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>BOLLINGER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FILMORE Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>RURAL</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>0090</u>	d. STREET ADDRESS (If outside, give location) <u>0090</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>CARL</u> Last <u>OSSIG</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1876</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
------------------	---------------------------	---	---------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED CYNTHIA OSSIG</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>499-28-1131</u>	17. INFORMANT <u>Mrs. Mae Nikolai, St. Louis Mo.</u>	Address <u>2742 North 4th St. St. Louis Mo. Road</u>
--	---	---	--

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>Acute Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Artery Occlusion</u>	
	DUE TO (c) <u>Coronary Atherosclerosis</u>	
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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT <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 <u>Lutesville, Mo.</u>	COUNTY _____ STATE _____
---	---	--	--	--------------------------

21. I attended the deceased from <u>Death upon my arrival</u> to <u>my arrival</u> and last saw her alive on _____ Death occurred at <u>3 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Glen E. Finkbeiner</u> 3	22b. ADDRESS <u>Lutesville, Mo.</u>	22c. DATE SIGNED <u>June 9, 1959</u>
---	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLEN ALLEN CEMETERY</u>	23d. LOCATION (City, town, or county) <u>GLEN ALLEN MO.</u>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <u>BAKER FUNERAL HOME</u>	ADDRESS <u>LUTESVILLE MO.</u>	25. DATE RECD. BY LOCAL REG. <u>6/12/59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Buford Crader</u>
---	----------------------------------	--	--

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 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

570  
0

JUN 30

JUN 30

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 *J. E. Graham* .....

Licensed Embalmer No. *4010* .....

P. O. Address *Lutesville, 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.