

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 21 1959

2 8269 **59-034159**
 REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN Saint Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 7519 Virginia Ave.	

3. NAME OF DECEASED (Type or print) JOE OSER, JR.	4. DATE OF DEATH SEPT. 8, 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/19/74	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wagon Maker	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Reading, Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Joseph Oser	13b. MOTHER'S MAIDEN NAME Margaret (unknown)	14. NAME OF HUSBAND OR WIFE Frances (Deceased)
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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) No None	16. SOCIAL SECURITY NO. 306-12-4209	17. INFORMANT Veronica Strohmeier	Address 7519 Virginia
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency		INTERVAL BETWEEN ONSET AND DEATH 4 hours
DUE TO (b) Myocardial infarction		
DUE TO (c) Arteriosclerotic Heart Dis. years		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Nemoptysis - undiagnosed cause	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 a.m. p.m.	Month, Day, Year
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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 Huntingburg, Indiana	COUNTY	STATE
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21. I attended the deceased from 9/6/59 to 9/8/59 and last saw her/him alive on 9/8/59 Death occurred at 5: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) Nicholas Owen M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 9/8/59
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23a. BURIAL, CREATION, REMOVAL (Specify) Removal	23b. DATE 9/8/1959	23c. NAME OF CEMETERY OR CREMATORY St/ Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Huntingburg, Indiana
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24. FUNERAL DIRECTOR Fendler Und. Co.	ADDRESS 7420 Michigan Ave.	25. DATE RECD. BY LOCAL REG. SEP 8'59	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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

W. J. Peters

Licensed Embalmer No. 376

P. O. Address 74 20 Mi

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.