

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10152**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 hours	c. CITY OR TOWN Bellefontaine Neighbors Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10084 Ashbrook Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Bernard Middle F Last Ostendorf	4. DATE OF DEATH Month October Day 17 Year 1960
---	---

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1896	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Punch Press Operator	10b. KIND OF BUSINESS OR INDUSTRY Emerson Electric Co	11. BIRTHPLACE (City and state or country) Glen Carbon, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	--

13a. FATHER'S NAME (retired) Benjamin Ostendorf	13b. MOTHER'S MAIDEN NAME Elizabeth Rosapul	14. NAME OF HUSBAND OR WIFE Anna Ostendorf
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1st World War	16. SOCIAL SECURITY NO. 488-10-8079	17. INFORMANT Address Mrs. Anna Ostendorf, 10084 Ashbrook Drive
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) Cerebral Hemorrhage	INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 331x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 Hour a.m. p.m. Month, Day, Year	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.) 3-19-60	20f. CITY, TOWN, OR LOCATION 10-17-60	COUNTY 10-17-60	STATE
---	--	--	---	---------------------------	-------

21. I attended the deceased from 3-19-60 to 10-17-60 and last saw him/her live on 10-17-60 Death occurred at 7:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) M.D. Johnson M.D.	22b. ADDRESS Ferguson Mo	22c. DATE SIGNED 10-18-60
--	------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct 21 1960	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
---	---------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av	25. DATE RECD. BY LOCAL REG. OCT 19 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	--	--

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Walter G. Beers

Licensed Embalmer No. 425

P. O. Address St. Louis

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