

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		a. STATE Mo. b. COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hospital		c. CITY OR TOWN Mehlville	
Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Box 636D	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First Middle Last John Osmak			Month Day Year 12-20-60			
5. SEX M	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/11/89	9. AGE (last birthday) 79	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) Wood worker		10b. KIND OF BUSINESS OR INDUSTRY American Car Foundry		11. BIRTHPLACE (City and state or country) Hungary		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME not known		13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE Mary		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 490-01-0592		17. INFORMANT Address Robert Schraut Mehlville Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	163x
	DUE TO (c)	
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 12-20-59 to 12-20-60 and last saw her/him alive on 5.3.60 Death occurred at Missouri Baptist m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Joseph Yem, M.D.</u>		22b. ADDRESS 390 W. St. Anthony Lane Florissant, Missouri		22c. DATE SIGNED 12-21-60
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/23/60	23c. NAME OF CEMETERY OR CREMATORY (Specify location, city, town, or county) Sunset Burial Park Affton Mo.		
24. FUNERAL DIRECTOR ADDRESS John L Ziegenhein & Sons 7027 Gravois		25. DATE RECD. BY LOCAL REG. DEC 22 1960	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>	

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

Arnold Benz

Licensed Embalmer No. 486

P. O. Address St. Louis

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