

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-025020

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6656 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUL 12 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>S</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Clayton</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7520 York Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Leonora</b> Middle <b>B.</b> Last <b>Osterwisch</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-9-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>
13a. FATHER'S NAME <b>Phillip Becker</b>		13b. MOTHER'S MAIDEN NAME <b>Huldah Guttwald</b>	14. NAME OF HUSBAND OR WIFE <b>William Osterwisch</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>331X</b>	
17. INFORMANT <b>Mr. William Osterwisch</b>		Address <b>7520 York Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>			<b>sev. years</b>
DUE TO (c) <b>Essential Hypertension</b>			<b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>			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
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 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 <b>8/3/49</b> to <b>7/4/62</b> and last saw her/him alive on <b>7/4/62</b> Death occurred at <b>about 10:32 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In blue or black ink) <b>Samuel E. Schechter M.D.</b>		22b. ADDRESS <b>8000 Bonhomme</b>	
22c. DATE SIGNED <b>7/6/62</b>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 7, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>B. Lupton and Sons 7233 Delmar Bly'd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 6 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>

Dr. Samuel Schechter  
Slavin Bldg.  
8800 Borhonne Ave.  
Pa. 58220—

9:15-12:15 } Friday  
1:15-5

*Autism*

**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 *Deanne H. Murray*

Licensed Embalmer No. 4011

P. O. Address *St. Louis, 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.