

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27873

FILED SEP 11 1945  
Registration District No. 207

Primary Registration District No. 5757

State File No. \_\_\_\_\_

Registrar's No. 107

1. PLACE OF DEATH:

(a) County Marion Co

(b) City or town Viechy Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Johnson Surg  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County Marion Co

(c) City or town Viechy Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thos E Ostrander

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race Wh

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Mary Ostrander

6. (c) Age of husband or wife if alive dead years \_\_\_\_\_

7. Birth date of deceased 8-1-1869  
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 1  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bloomington Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name Dennis Ostrander

13. Birthplace Ill  
(City, town, or county) (State or foreign country)

14. Maiden name Rachel McCall

15. Birthplace Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Ostrander

(b) Address Viechy MO

17. (a) Burial (b) Date thereof 9-7-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker cem

18. (a) Signature of funeral director W E Richler

(b) Address St James MO

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 2  
year 1945 hour 5:30 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 27/45  
1945 to Aug 2 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Thromb Myocardialis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy X 9/7/45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work (e) Means of injury \_\_\_\_\_

23: Signature W E Jones (M. D. or other) \_\_\_\_\_

Address Belle Date signed 9/7/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1526

(Licensed Embalmer's Statement on Reverse Side)

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed W. E. Lucklider

Licensed Embalmer No. 1970

P. O. Address St James 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 207

Primary Registration District No. 5757

1. PLACE OF DEATH:

(a) County Marie  
(b) City or town Rural Johnson Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Thos E. Ostrander

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of decedent aug 1 (Month) 1 (Day) 1945 (Year)

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Mo (City, town, or county) Ill (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Farmer

12. Name Bernice Beltrando

13. Birthplace N. Y. (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Rose McLaughlin

15. Birthplace Ill (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Chas. Beltrando

(b) Address Vicksy, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation Walker Cem

18. (a) Signature of funeral director W. E. Kichler

(b) Address St James Mo

19. (a) 19-8-45 (Date received local registrar) (b) Pauline Howard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marie  
(c) City or town Vicksy Johnson Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 2 Year 1945 hour \_\_\_\_\_ minute 50 P. M.

21. I hereby certify that I attended the deceased from Aug 2 to Aug 2, 1945 and that death occurred on the date and hour stated above. Immediate cause of death Myocardial Infarction

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. E. Kichler (M. D. or other) \_\_\_\_\_

Address Build Mo Date signed 9/7/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

S-27873