

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

State File No. 35202
9114

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY _____					
b. CITY OR TOWN MO. St Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN ST LOUIS		2089			
d. FULL NAME OF HOSPITAL OR INSTITUTION 8546 E. Gilmore				d. STREET ADDRESS (If rural, give location) 8546 E. Gilmore					
3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) _____ c. (Last) Oswald			4. DATE OF DEATH (Month) 10 (Day) 25 (Year) 1950						
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3/1/1887	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 10 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLWRIGHT		10b. KIND OF BUSINESS OR INDUSTRY SOAP INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mary Oswald				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 489-03-5206		17. INFORMANT'S SIGNATURE OR NAME Mary Oswald ADDRESS 8546 Gilmore					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Pt. lung.				DUE TO (b) _____				1 year	
ANTECEDENT CAUSES				DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. metastases to brain, neck									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION non-resectable Ca Rt lung				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 162X					
22. I hereby certify that I attended the deceased from Nov , 19 29 to Oct 25 , 19 50 that I last saw the deceased alive on Oct 25 , 19 50 , and that death occurred at S.P.M. , from the causes and on the date stated above.									
23a. SIGNATURE Joseph L Lucido M.D.				23b. ADDRESS No. Theatre Bldg		23c. DATE SIGNED 10/26/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/28/50		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.			
DATE REC'D BY LOCAL REG. OCT 27 1950		REGISTRAR'S SIGNATURE J. B. Susater		25. FUNERAL DIRECTOR'S SIGNATURE Ed. Rockson ADDRESS 3516 N. W. St.					

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

[Handwritten signature]

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

[Handwritten signature]
Student Embalmer No.....
Licensed Embalmer No. 4053
P. O. Address [Handwritten address]

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.