

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

39541

9790

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SAINT LOUIS</u>		c. LENGTH OF STAY (in this place) <u>11 days</u>	a. STATE <u>Illinois</u> b. COUNTY <u>Adams</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Quincy</u> <u>8/20</u>	
		d. STREET ADDRESS (If rural, give location) <u>1508 Locust</u> <u>8</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>BERTHA</u>	b. (Middle)	c. (Last) <u>OSTERMUELLER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>4</u> <u>51</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 5. 1898</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Quincy Illinois</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>Frank Winking</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Frese</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Ostermueller</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Albert Ostermueller</u>	ADDRESS <u>Quincy Ill</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intermedullary Brain Tumor, Malignant</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>11-4-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Intermedullary Brain Tumor, Malignant</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>193x</u>
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22. I hereby certify that I attended the deceased from Oct. 24, 1951, to Nov. 4, 1951, that I last saw the deceased alive on Nov. 4, 1951, and that death occurred at 12:25p.m., from the causes and on the date stated above. /

23a. SIGNATURE (Degree or title) <u>Dr. Dan L. Morgan M.D.</u>	23b. ADDRESS <u>BARNES HOSPITAL</u>	23c. DATE SIGNED <u>Nov. 4 51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11-5-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>Quincy Ill</u>
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DATE REC'D BY LOCAL REG. <u>NOV 5 1951</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D. R.P.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 .....  
Student Embalmer

Signed

*John S. Dennehy*

Licensed Embalmer No. *4194*

P. O. 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.