

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42645  
242  
State File No. \_\_\_\_\_

FILED DEC 19 1951

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Charles</u>		c. LENGTH OF STAY (In this place township) <u>5 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		<u>2039</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give name of institution) <u>Our Lady of Mt. Carmel</u>				d. STREET ADDRESS (If rural, give location) <u>6040 Juniata St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>			b. (Middle) _____		c. (Last) <u>Oldenburg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-10-51</u>
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>5-22-1869</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unk. Deeken</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Theodore Oldenburg</u>		
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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>St. Louis, Mo.</u> <u>Henry Oldenburg</u> ADDRESS <u>6040 Juniata St.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbid 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. <u>Hypertensive Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>4200</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, shop, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>59</u> to <u>November</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>November</u> , 19 <u>51</u> , and that death occurred at <u>5:40</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. E. Kister, M.D.</u>				23b. ADDRESS <u>207 N. 5th St. St. Charles, Mo.</u>		23c. DATE SIGNED <u>Dec. 10, 1951</u>	
24a. BURIAL OR CREMATION REMOVAL (Specify) <u>Motor Burial</u>		24b. DATE <u>12/12/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-10-51</u>		REGISTRAR'S SIGNATURE <u>Ranice Hamilton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schmitt</u>		ADDRESS <u>3125 Lafayette</u>	

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

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File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

DEC 17 1951

RECEIVED

DEC 17 1951

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 Joseph Hollmer

Licensed Embalmer No. 41014

P. O. Address 3125 Lafayette Ave

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.