

Health, Public Service  
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 -57  
 All diseases in Part I must be causally related.  
 MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

46500

STATE FILE NUMBER

FILED JAN 13 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12635

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2811 HENRIETTA</u>		Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>231 2811 HENRIETTA</u>	
3. NAME OF DECEASED (Type or print) First <u>NAOMI</u> Middle <u>G</u> Last <u>WOSMAN</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>28</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 13 1898</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEVATOR OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LESSER-GOLDMAN CO</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	
13a. FATHER'S NAME <u>DAVID GALVIN</u>		13b. MOTHER'S MAIDEN NAME <u>ANNE GALVIN</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM JAMES WOSMAN</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>494-10-8533</u>		17. INFORMANT Address <u>MARY ANN WOSMAN 2811 HENRIETTA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>about 4 yrs.</u> <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>myocardial decompensation</u>					
DUE TO (c) <u>arteriosclerotic and hypertensive coronary disease</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a)					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.) <u>420.1</u>		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <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 <u>1951</u> to <u>Dec 28, 1957</u> and last saw her alive on <u>Dec 16, 1957</u> Death occurred at <u>205 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated					
22a. SIGNATURE (Degree or title) <u>Arthur K. Frushoff M.D.</u>			22b. ADDRESS <u>7500 Des Moines</u>		22c. DATE SIGNED <u>12-30-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 31 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO</u>
24. FUNERAL DIRECTOR <u>Thomas Kutie 2906 Brannis</u>			25. DATE RECD. BY LOCAL REG. <u>DEC 31 57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>m JB</u>	

3-7 P.M.  
7:00  
Newark, N.J.

**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 *Leop. B. ...*

Licensed Embalmer No. *3989*

P. O. Address *Louis, N.J.*

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.