

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020016

STATE FILE NUMBER

5078

FILED MAY 19 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

100
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 633 Michigan		Length of stay in lb 1	d. STREET ADDRESS 4633 Michigan
3. NAME OF DECEASED (Type or print) Lena Ost		First	Middle
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Patterson, N.J.
13a. FATHER'S NAME John Ogle		13b. MOTHER'S MAIDEN NAME Reginia Schoenbachler	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, Unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk.	17. INFORMANT Address Leola Lawrence 4633 Michigan Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 420-0			INTERVAL BETWEEN ONSET AND DEATH 1 hr 9425
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.)	
20c. TIME OF INJURY Hour a.m. p.m.		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 3-1-49 to 5/11/58 and last saw her/him alive on April 14, 1958 Death occurred at 8:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE K. Nachreiner M.D.		22b. ADDRESS 4065 S. Grand	22c. DATE SIGNED 5/13/58
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/14/58		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. MAY 13 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Halley P. Zeller Jr*
Licensed Embalmer No. *14950*
P. O. Address: *St. Louis*

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.