

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046131

STATE FILE NUMBER

318

1003

Registrar's No. 12328

FILED JAN 5 1959

Registration District No.

Primary Registration District No.

300

-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>1</u>		
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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ALEXIAN BROS. HOSPITAL</u>		Length of stay in 1b <u>39</u>	d. STREET ADDRESS <u>6645 OLEATHA</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH F OSWALD</u>			4. DATE OF DEATH Month Day Year <u>DEC 19 1958</u>		
5. SEX <u>MALE</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>FEB 2 1868</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED AUTO INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>		13a. FATHER'S NAME <u>FRANK OSWALD</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>ANNA OSWALD (DEC'D)</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>498-09-8802</u>	
17. INFORMANT Address <u>MARY BROSS 509 SUNNINGWELL DR.</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>Arteriosclerotic Heart Dis</u> DUE TO (b) <u>Sen. Arteriosclerosis</u> DUE TO (c) <u>420.0</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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 .Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis, Mo</u>	
21. I attended the deceased from <u>Oct 1958</u> to <u>12/19/58</u> and last saw him alive on <u>12/19/58</u> . Death occurred at <u>5:50 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>8059 Watson Rd</u>		22c. DATE SIGNED <u>12/20/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 22 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>	
23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		23e. STATE <u>MO</u>		24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravoia</u> ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>DEC 22 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> m. J. B.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2010 / 8 20 6

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 *James C. Will*

Licensed Embalmer No. *4347*

P. O. Address *2906 Prairie*

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.