JAN 5 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34101

File No. 34101

Registered No. 298

1. PLACE OF DEATH

County Marion — Registration District No. 547

Township ~~Mason~~ — Primary Registration District No. 2829

City Hannibal (No. 1105 ~~Sierree~~ Sierra St. ..... Ward)

2. FULL NAME Katherine M. Osborne

(a) Residence. No. 1105, ~~Sierree~~ Sierra St. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where ~~death occurred~~ yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3, 1912

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	14	2	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Child 95B 11A 109A

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER David Osborne

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Bessie L. Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Mo.

14. INFORMANT David Osborne
(Address) 1105 Serree St.

15. FILED 11/12, 1927 O E Strode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

5

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 7, 27 19

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1927, to Nov 7, 1927 that I last saw her alive on ....., 19....., and that death occurred, on the date stated above, at 11:20 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(To Toxic heart dises)

Endocarditis + pericarditis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Flu + Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Wm H Hays, M. D

, 19 (Address) Hannibal Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mount Olivet	11/9 27 19
20. UNDERTAKER	ADDRESS
Wm. M. Smith	Hannibal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

13-3-4

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.
County Marion — Registration District No. 547 — File No.
Township — Primary Registration District No. 3029 — Registered No. 298
City Hannibal (No. ..... St. ..... Ward)

2. FULL NAME Katherine M. Osborne
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3-1912

7. AGE: Years 15 Months 3 Days 4 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 11/12 1927 C E Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 7 1927

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THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-34101