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

Do not use this space.

1. PLACE OF DEATH

County Knox — Registration District No. 444 — File No. 1688

Township Ingalls — Primary Registration District No. 5603 — Registered No. 1

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Clarance Kurfoot Oshner

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 26-1872

7. AGE: Years 57 — Months 10 — Days 19 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark Co Mo

PARENTS

10. NAME OF FATHER Samuel Oshner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Switzerland
12. MAIDEN NAME OF MOTHER Sallie Kurfoot
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Lewis Co Mo

14. INFORMANT Mrs. Clarance Oshner
(Address) La Belle Mo

15. FILED Jan 17 1930 J R Northcutt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jany 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 15, 1930 that I last saw him alive on Jan 9, 1930, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of prostate gland
51C
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 49
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Abial McReynolds M.D.
Jan 17, 1930 (Address) Knox City 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: La Belle Mo — DATE OF BURIAL: Jany 17 1930

20. UNDERTAKER: La Belle Cemetery James T Coder — ADDRESS: La Belle Mo

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.