

FILED MAR 12 1940

Registration District No. _____

Primary Registration District No. **2001**

Registrar's No. **168**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
830 N. Kansas **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank Louis Osborne **216**

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife May Osborne 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 1, 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Muscotah Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business _____

MOTHER FATHER { 12. Name Jesse Osborne **1**

13. Birthplace Cedar Point Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Anna Gwinn

15. Birthplace Fulton Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Osborne

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Feb. 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo. **290**

19. (a) 2/20/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 830 N. Kansas
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17.
year 1940 hour 5 minute 2. M.

21. I hereby certify that I attended the deceased from June 6, 1938, to Feb. 17, 1940
that I last saw him alive on Feb. 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death (Uraemic)
Tabillary Carcinoma
of bladder, primary
Due to _____

Due to _____ **51**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Biopsy for Examination
Of operations Esophageal stricture, Dupuytren's
Of autopsy no.

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) _____
While at work? _____ (c) Means of injury _____

23. Signature W.S. Sewell (M. D. or other) **imb**
Address Springfield Mo. Date signed 2-20-40

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed.....

Licensed Embalmer No. *2457*

P. O. Address..... *Springfield, Mo.*

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 this body is not embalmed, above space should be left blank.