

Registration District No. 4  
*MAILED OCT 18 1940*

Primary Registration District No. 5615

Registrar's No. 4

1. PLACE OF DEATH:  
(a) County LACLEDE  
(b) City or town AGLAZE TWP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
LINNCREEK STAR RT. LEBANON MO  
(If not in hospital or institution, write street number or location) 20  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 32 yrs  
years, months or days

3. (a) PRINT FULL NAME WILL OSBORN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife PEARL DAVIS 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased JAN 26 1876  
(Month) (Day) (Year)

8. AGE: Years 64 Months 7 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ILL 1  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER 1

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name CHRISTOPHER OSBORN 9  
13. Birthplace ILL  
(City, town, or county) (State or foreign country)  
14. Maiden name NOT KNOWN  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Will Osborn  
(b) Address Linn Creek Rt. Lebanon Mo  
17. (a) Burial (b) Date thereof 9-18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation LEBANON

18. (a) Signature of funeral director PALMER'S 405  
(b) Address LEBANON MO  
19. (a) 9-18-40 (b) D. A. Atkins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County LACLEDE  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. LINNCREEK RT. LEBANON MO  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month SEPT day 16  
year 1940 hour 8 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from 6-19  
1940 to 9-17 19 40  
that I last saw him alive on 8/20/ 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Broncho-Pneumonia Duration 2 weeks

Due to Hypertension - J.H.V.  
Due to Stroke

Other conditions (include present only within 3 months of death) Arterio Sclerosis

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_  
(c) 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Wm. J. Warboja (M. D. MI)  
Address Lebanon Date signed 9-17-40

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.

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1499

Date Filed 10-14-40

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1161

P. O. Address Lenora 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.