

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

3622
 Do not use this space.

1. PLACE OF DEATH

(a) County Holmes Registration District No. 618
 (b) Township Holmes Primary Registration District No. 4369 Registered No. _____
 (c) City Burlington, Ia. Mo. (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 35 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 74 yrs. mos. ds.

2. PRINT FULL NAME

WILLIAM M. OSBORN
 (a) Residence, No. Burlington, Ia. Mo. St. 0 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 10 - 1867
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 00 21
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Rail Carpenter
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) 1931- 11. Total time (years) spent in this occupation 40

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

Brauer Co. Ohio

FATHER 13. NAME

Cassius Osborn

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

Ohio

MOTHER 15. MAIDEN NAME

Mary Ann Gibbs

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

Unknown

17. INFORMANT (ADDRESS)

Lyman Mc Intyre Burlington, Ia. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Ohio Ceper. 2-2-1941

19. FUNERAL DIRECTOR (ADDRESS)

J. S. Cunniff Larcher Mo.

20. FILED _____, 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 - 1941

22. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1941, to Jan 31, 1941. I last saw him alive on Jan 29, 1941. Death is said to have occurred on the date stated above, at 6:30 P.M.. The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset 1/31/41
Arteriosclerosis
Septicemia
 Other contributory causes of importance: Septicemia
Arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) B. J. Byland M. D.
 (Address) Burlington, Ia. Mo.

Review 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.

STATEMENT BY LICENSED EMBALMER

I, W. S. Sumner, Licensed Embalmer No. 3381
hereby certify that the body recorded on the reverse side of this certificate was embalmed by W. S. Sumner
L. E.
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed W. S. Sumner
Licensed Embalmer No. 3381

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36 22

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 6.18

Primary Registration District No. 4369

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Burlington, Ia
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Wm M. 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 S

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

7. Birth date of deceased. 1-10-1862
(Month) (Day) (Year)

8. AGE: Years 79 Months 21 Days _____
If less than one day _____ min.

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

10. Usual occupation Ret Carpenter

11. Industry or business _____

12. Name Cassius Osborn

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Osborn

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

16. (a) Informant Lyman Medley

(b) Address Burlington, Ia Mo

17. (a) Burial (b) Date thereof 2-2-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ohio cem

18. (a) Signature of funeral director W. S. Clement

(b) Address Larkin St Mo

19. (a) Feb 7 41 (b) J. R. Hann
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
 that I last saw him _____ alive on _____ 19 _____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Due to Otitis media
Influenza
 Due to Scrub typhus
 Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 _____
 (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 B. F. Byland (M. D. or other) _____
 Address Burlington, Ia Date signed _____

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

STANDARD

