

State File No.

Registrar's No.

ED. AUG. 9 1943 #158
Registration District No.

Primary Registration District No. 2000

597

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution **Home 1038 E. BLAINE**
(d) Length of stay: In hospital or institution (Specify whether)

In this community years, months or days

3. (a) PRINT FULL NAME **OLIVER L. COSSAIRT**

3. (b) If veteran, name war **Unk.** 3. (c) Social Security No. **Unk.**

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

6. (b) Name of husband or wife **Unk.** 6. (c) Age of husband or wife if alive **Unk.** years

7. Birth date of deceased **Nov 3 1877**
(Month) (Day) (Year)

8. AGE: Years **165** Months **8** Days **21** If less than one day hr. min.

9. Birthplace **Urbana Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Custodian H. School**
Kenil

11. Industry or business

12. Name **JAMES F COSSAIRT**

13. Birthplace **Unk.** **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY E LINDSEY**

15. Birthplace **Unk.** **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Wm Perry**
(b) Address **Springfield Mo**

17. (a) **Burial** (b) Date thereof **7-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **East Lawn Cem**
18. (a) Signature of funeral director **J. W. Klingman also**
(b) Address **Springfield Mo**
19. (a) **7-26-43** (b) **J. W. Klingman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Greene**
(c) City or town **Springfield**
(d) Street No. **1038 E Blaine**
(e) If foreign born, how long in U. S. A? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1943** hour **6** minute **00** P. M.

21. I hereby certify that I attended the deceased from **June 1 1943** to **July 24 1943**
that I last saw him alive on **July 23 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of superior right maxilla**
Due to

Due to
Other conditions **458**
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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

While at work (Specify type of place) (a) Means of injury
23. Signature **Arthur Knight** M. D. or other
Address **450 1/2 E. Cowi** Date signed **7-26-43**

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

MOTHER FATHER

984

supd. Mo.

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. 4071

P. O. Address _____

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, fact should be so stated above.