

FILED SEP 28 1943
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Hannas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

In this community 43 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Veda Osborne

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William J Osborne 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May 23 1900
(Month) (Day) (Year)

| | | | | |
|---------|-------|--------|------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | 43 | 3 | 23 | _____ hr. _____ min. |

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Zimmerman

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

14. Maiden name Zelpha Jane Dean

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

16. (a) Informant William J Osborne

(b) Address 3404 Anderson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-43
(Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director W. J. Brown

(b) Address 20th Danwood

19. (a) 9-17-43 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Hannas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3404 Anderson
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 16
year 1943 hour 9:30 min 2 M.

21. I hereby certify that I attended the deceased from 9/12/43
to 9/16/43, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 10 mo

Due to 46 h

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

of autopsy Cerebral thrombosis
General metastases

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) (a) Means of injury _____

23. Signature J. E. Brown M. D. Date signed 9/17/43
Address 110 3rd Ave Date signed 9/17/43

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..... *Charles M. Quirk*

Licensed Embalmer No. *3774*

P. O. Address *H. Q. 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, fact should be so stated above.