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-42
7-39
K32873

MAY 8 1944
Registration District No. 8 1045 7

Primary Registration District No. 3040

Registrar's No. 5-1

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution:
308 Relay St 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... 20 yrs (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston ⁵⁹

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

(d) Street No. 505 Webster ²
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country..... 0

3. (a) PRINT FULL NAME Matilda Osright

3. (b) If veteran, name war..... L

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1944 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 14
..... 14 to April 20, 1944;
that I last saw her alive on April 20, 1944;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James W Osright

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Dec-29-1860
(Month) (Day) (Year)

Immediate cause of death Bronchial pneumonia ^{6 days}

8. AGE: Years 83 Months 3 Days 20 If less than one day
hr. min.

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: 101

Of operations.....

Of autopsy.....

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

10. Usual occupation At Home

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER, FATHER {

11. Industry or business

12. Name Jacob S Fraubion

13. Birthplace Liberty Mo-0
(City, town, or county) (State or foreign country)

14. Maiden name Sarah C Gears

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

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 P. A. Brennan (M. D. number).....
Address Chillicothe, Mo Date signed 4/22/44

16. (a) Informant Mrs. Marie Watts

(b) Address Chillicothe, Mo

17. (a) Burial (burial, cremation, or removal) (b) Date thereof 4-29-44
(Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director James D Sordor ^{F 70}

(b) Address Chillicothe, Mo

19. (a) April-24 (Date received local registrar) (b) L. V. Elba ^{Corsy}
(Registrar's signature)

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

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 James D. Gordon

Licensed Embalmer No. 1870

P. O. Address Chillicothe, 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.