S. No. 2
OM—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21575

FILED JUN 22 1944

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 494

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield, 513 E. Monroe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mary E. High Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In ~~hospital~~ or institution 14 yr 6 mo. (Specify whether years, months or days)
In this community 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Webster
(c) City or town Rogersville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Minerva Osborn
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or ~~wife~~ Riley Osborn
6. (c) Age of husband or ~~wife~~ if alive Dec. years
7. Birth date of deceased Aug. (Month) 24, (Day) 1865 (Year)

8. AGE: Years 78 Months 9 Days 18 If less than one day _____ hr. _____ min.
9. Birthplace Christian Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation House Keeper.
11. Industry or business _____
12. FATHER Name John Reed
13. FATHER Birthplace UNK. (City, town, or county) Tennessee (State or foreign country)
14. MOTHER Maiden name UNK. Roller
15. MOTHER Birthplace Unknown (City, town, or county) UNK. (State or foreign country)
16. (a) Informant Mrs. Tip Willis
(b) Address Rogersville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-44 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Manser Cem.
18. (a) Signature of funeral director Kelley-Ferrell
(b) Address Rogersville, Mo.
19. (a) 6-13-44 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11 year 1944 hour 5 minute 15 P.M.
21. I hereby certify that I attended the deceased from 6, 9, 1944, 19____, to 6, 11, 1944, 19____; that I last saw her alive on 6, 11, 1944, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Hemorrhage, cerebral	short
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. ~~or other~~)
Address Springfield, Mo. Date signed 6, 13, 44

984

(Licensed Embalmer's Statement on Reverse Side)

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 K. K. Kelley

Licensed Embalmer No. 9394

P. O. Address Seymour, 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.