

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28886

FILED SEP 13 1944

Registration District No. 324

Primary Registration District No. 6-93

Registrar's No. 156

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Mo. State School 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard Co.

(c) City or town Franklin R.F.D.
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Annie Marie Osier

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced -0

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

7. Birth date of deceased May 6 - 1928
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

16 3 23 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Wm Osier

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

14. Maiden name Rosa, Suter

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

16. (a) Informant Mo State School Records

(b) Address Marshall, Mo

17. (a) Removal (b) Date thereof 8-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Franklin, Mo

18. (a) Signature of funeral director Campbell & Lewis

(b) Address Marshall, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 30 day..... year 1944 hour 4:55 minute P M.

21. I hereby certify that I attended the deceased from July 1902 to Aug 30 - 1944, 19.....; that I last saw her alive on Aug 30 - 44, 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
obstructive jaundice
epilepsy

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?.....

While at work?..... (Specify type of place) (e) Means of injury 0

23. Signature L. S. Jones, M.D. (M. D. or other).....
Address Marshall, Mo. Date signed 8-30-44

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

MOTHER FATHER

12 18

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 9-12-44

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

B.W. Campbell Jr.

Licensed Embalmer No.

3467

P. O. Address

Marshall, 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.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ms. State School
(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)

3. (a) PRINT FULL NAME

Annie M. Oser

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 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 May 6 (Month) (Day) (Year)

8. AGE: Years 16 Months 3 Days 12 If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-3-44 (b) Ms. Oser (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1944
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

STIPULENTARY

28886