

1. PLACE OF DEATH:

(a) County St. Clair  
(b) City or town Osceola  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 7 Weeks  
years, months or days

3. (a) PRINT FULL NAME Robert M. Bishop  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Sarah Bishop  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 24 1856  
(Month) (Day) (Year)

8. AGE: Years 88 Months 3 Days 15 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Francis  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant George Bishop  
(b) Address Osceola Missouri  
17. (a) Burial (b) Date thereof 10-11-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Holsapple Cemetery

18. (a) Signature of funeral director Osceola Funeral Home  
(b) Address Osceola Missouri

19. (a) 10-11-'44 (b) J. B. Goodrich  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair 93  
(c) City or town Collins  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9  
year 1944 hour 10 minute A M.

21. I hereby certify that I attended the deceased from October 3, 1944, to October 9, 1944;  
that I last saw him alive on October 8, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Myocarditis

Due to Septic arteriosclerosis

Due to \_\_\_\_\_

Other conditions 93d  
(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? \_\_\_\_\_ (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 2

23. Signature R. Mark Todd (M.D. or other) 20  
Address Osceola Missouri Date signed 10/11/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 10-44-1289

Date Filed 11-13-44

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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 Paul J. Trestone

Licensed Embalmer No. 3990

P. O. Address Ossola MD

**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.**