

FILED JAN 15 1946

STANDARD CERTIFICATE OF DEATH

State File No. 41255

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 985

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town RURAL, S. CAMPBELL TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
In this community 17 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Okla (b) County Kay
(c) City or town Ponce City Okla
(If outside city or town limits, write "RURAL")
(d) Street No. North 3rd St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME PATRICIA ANN O. R. S. BORN

3. (b) If veteran, name war NONE
3. (c) Social Security No. N.A.K.

4. Sex Female, 5. Color or race White, 6. (a) Single, widowed, married, divorced, separated
6. (b) Name of husband or wife H. F. F. OSBORN, 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased Unknown UNK. 1920
(Month) (Day) (Year)

8. AGE: Years 25, Months UNK., Days UNK., If less than one day hr. min.

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

10. Usual occupation Nurse

11. Industry or business

12. Name J. L. SULLIVAN
13. Birthplace Unknown UNK. 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace UNK. UNK. 2
(City, town, or county) (State or foreign country)

16. (a) Informant Lucie Osborn
(b) Address Marshfield, Mo.

17. (a) Burial (b) Date thereof 12-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marshfield, Mo.

18. (a) Signature of funeral director Rev. Fleming
(b) Address Marshfield, Mo.

19. (a) 12-3-45 (b) S. W. Stewart
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day 2nd year 1945 hour 12: minute 15 p.m.

21. I hereby certify that I attended the deceased from Nov. 17, 1945 to Dec. 2, 1945, that I last saw her alive on Dec. 2, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: General Peritonitis, Duodenal Ulcer, Adhesions
Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: 129
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
23. Signature: William S. Kitzel
Address: Springfield, Mo. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1950
JAN 5 11 17 AM

W
RICKA
M
HEE

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.....
Licensed Embalmer No. 3312
P. O. Address.....

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.

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