

No. 2  
8-43  
5-17-39  
1 X37823

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28139

State File No. \_\_\_\_\_

FILED AUG 20 1946

Registration District No. 314

Primary Registration District No. 4459

Registrar's No. \_\_\_\_\_

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: 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 25 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair 93

(c) City or town Osceola 2  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fred Decker

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. #16-10-4785

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
year 1946 hour 3 minute 15 a. M.

21. I hereby certify that I attended the deceased from April 22, 1946, to April 22, 1946;

that I last saw him alive on April 22, 1946;

and that death occurred on the date and hour stated above.

4. Sex m

5. Color or race w

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

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased April 9 1867  
(Month) (Day) (Year)

Immediate cause of death Bronchopneumonia

Due to Intestinal Obstruction

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

8. AGE: Years 78 Months 13 Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Laborer

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Martin Decker

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

14. Maiden name Not known

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

16. (a) Informant Mrs. Annie Decker

(b) Address Osceola, Mo

22. If death was due to external causes, fill in the following:

(c) 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? \_\_\_\_\_

17. (a) Burial (b) Date thereof Apr. 23 1946  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Cemetery

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

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

(b) Address Osceola, Missouri

19. (a) 4-25-46 (b) Paul Decker  
(Date received local registrar) (Registrar's signature)

23. Signature P. Frank Todd, M.D. (M. D. or other) \_\_\_\_\_

Address Osceola, Missouri Date signed 4/27/46

584 (Licensed Embalmer's Statement on Reverse Side)

REG-80

DIR

DRIFT MA 7

7-46-83

Date Filed

8-14-86

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Passaic, NJ

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.