

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12654

FILED APR 24 1947

Registration District No. 477

Primary Registration District No. 3008

Registrar's No. 148

1. PLACE OF DEATH:

(a) County 6 allaway

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

(c) Name of hospital or institution:
State Hospital No 1. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1.3 years 6 months
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. St. Louis City Sausalito
(If rural, give location)

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

3. (a) PRINT FULL NAME WILLIAM OSBORNE

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

4. Sex M. O 5. Color or race N.

6. (a) Single, widowed, married, divorced S. O

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

7. Birth date of deceased 12 25 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>3</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER

12. Name D. K.

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

14. Maiden name D. K.

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

16. (a) Informant Hospital Records
(b) Address Fulton Mo.

17. (a) Removal (b) Date thereof 4 18 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbian

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia Mo.

19. (a) 4-18-1947 (b) Jesse M. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14
year 1947 hour 9 minute A. M.

21. I hereby certify that I attended the deceased from 4-10-47, 19____ to 4-14-47, 19____
that I last saw him alive on 4-13-47, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
chronic myocarditis

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 935

Of operations _____

Of autopsy _____

Duration _____

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 _____

Signature R. P. Price (M.D. or other) _____
Address Fulton Mo. 4-14-47

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

14
1
2

RECEIVED
District Health Officer No. 9,
District File Number 4-23-47
Date Filed

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.....

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.