

No. 2  
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7-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19209  
State File No.  
5451  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: #121 California 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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME JOHN T. OSBORN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 272-01-3856A

4. Sex M 5. Color or race W 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 May 21 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 0 9 hr. min.

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

10. Usual occupation Electrician

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

12. Name Allison Osborn

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

14. Maiden name Katherine Hooper

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

16. (a) Informant Maybelle Osborn

(b) Address 4121 California

17. (a) Cremation Date thereof 6-3-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director John Ziegenhain

(b) Address 7027 Grand

19. (a) JUN 2 1947 (b) J. F. Bradock  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County oac  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4121 California 9  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 13

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 the year 1947 hour 7 minute 20 PM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 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 Compensatory Thrombosis

Due to Hypertension

Due to CHF

Other conditions \_\_\_\_\_  
(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 3

23. Signature Patrick J. Taylor (M. D. or other) \_\_\_\_\_

Address Deputy Coroner Date signed 6-2-47

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

*Ward*

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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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravois*

**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.**