

FILED SEP 8 1947

Registration District No.

Primary Registration District No. 41695374

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Osborn (Rural)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Year (Specify whether years, months or days)
In this community 1 Year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb 32
(c) City or town Osborn (Rural))
(If outside city or town limits, write "RURAL"))
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANCIS MARION KARR

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

4. Sex Male D 5. Color or race W 6. (a) Single, widowed, married, divorced, Widowed

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

7. Birth date of deceased May 1 1858 (Month) (Day) (Year)

8. AGE: Years 89 Months 3 Days 8 If less than one day hr. min.

9. Birthplace Warren County Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Robert Karr
13. Birthplace Illinois (City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Frank Karr
(b) Address Osborn Mo R F D
17. (a) Removal (b) Date thereof 8-10-1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation XXXXX Abingdom Illinois
18. (a) Signature of funeral director Pilcher Funeral Home
(b) Address Maysville Mo.

19. (a) 8/9-47 (b) A. S. Searles (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1947 hour 2 minute A M.

21. I hereby certify that I attended the deceased from 9:00 1947 Aug 8 1947 that I last saw him alive on Aug 8 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy H. B. B. 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
23. Signature Harold Taylor M. D. or other. D.D. Address Maysville Mo Date signed 8-9-47

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

23

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

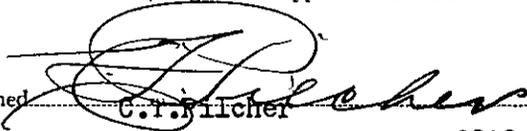
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~me~~ by

Neal R. Dawson

Registered Apprentice No. 484

working under my personal supervision.

Signed


C. F. Filcher

Licensed Embalmer No. 3960

P. O. Address. Maysville Mo.

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.