S. No. 2
—12-45
5-17-39
PI X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31539

Registration District No. 946 Primary Registration District No. 3026 Registrar's No. 275

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town INDEPENDENCE (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RESIDENCE (816 W. LEXINGTON) (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 63 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town INDEPENDENCE (If outside city or town limits, write "RURAL")
(d) Street No. 816 W. LEXINGTON (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM OSCAR CLOSSON
3. (b) If veteran, name war NO
3. (c) Social Security No. NO
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of ~~husband~~ or wife PHOEBE
6. (c) Age of ~~husband~~ or wife if alive 87 years
7. Birth date of deceased 1 (Month) 13 (Day) 1854 (Year)
8. AGE: Years 93 Months 8 Days 5 If less than one day hr. min.
9. Birthplace BLACKBERRY : KANE COUNTY : ILLINOIS (City, town, or county) (State or foreign country)
10. Usual occupation RETIRED
11. Industry or business STEEL MILLS
FATHER 12. Name NO RECORD
13. Birthplace NO RECORD (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name NO RECORD
15. Birthplace NO RECORD (City, town, or county) (State or foreign country)
16. (a) Informant MRS. PHOEBE CLOSSON
(b) Address 816 W. LEXINGTON Indep. Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation MOUND GROVE
18. (a) Signature of funeral director [illegible]
(b) Address 815 W. MAPLE AVE
19. (a) 9-20-47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18 year 1947 hour 6 minute 20 P. M.
21. I hereby certify that I attended the deceased from Feb 15, 1945 to ~~19~~, to Sept 18, 1947, that I last saw ~~him~~ alive on August 27, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Sclerosis	3 years
Due to: Senescence	5
~~Due to~~: Has been blind bedfast & helpless past year	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: no operation	
Of autopsy: no autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. H. Allen M.D. (M. D. or other)
Address Independence Mo Date signed 9/19/47

(Licensed Embalmer's Statement on Reverse Side)

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. M. Weir

Licensed Embalmer No. 3156

P. O. Address Independence

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.