

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 10 1949

State File No. _____

No. 300
10. 48

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

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>261</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. LENGTH OF STAY (In this place) <u>1 Mo. 12 da.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Webster Grove</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>			b. (Middle) _____		c. (Last) <u>Osborn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 2 1949</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>8-28-1905</u>		9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME _____			13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records Fulton, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute cardiac decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General paresis</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>0.15 X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>8-1-49</u> , 19 <u>49</u> , to <u>8-2</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>49</u> , and that death occurred at <u>4:45 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>J. M. Miller, M.D.</u> (Degree or title)			23b. ADDRESS <u>State Hospital, Fulton, Mo</u>			23c. DATE SIGNED <u>8-2-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 4 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Father Dejon Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Webster Grove, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Aug 2 1949</u>		REGISTRAR'S SIGNATURE <u>Muretha Lawrence</u> <u>426</u>		25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS <u>Susie Lewis White, Miss</u>			

District File Number _____
District Health Officer No. 9,
AUG 9 1949
RECEIVED

AUG 10 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *A. D. Richaden*

Licensed Embalmer No. *2928*

P. O. Address *St Louis 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.