

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

BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 4219 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY Hickory		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Hickory	
b. CITY (If outside corporate limits, write RURAL and give township) Weaubleau		c. CITY (If outside corporate limits, write RURAL and give township) Weaubleau	
c. LENGTH OF STAY (in this place) 38 yrs		d. STREET ADDRESS (If rural, give location) 0430	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) Oscar R. Magnuson			4. DATE OF DEATH (Month) (Day) (Year) 7-26-54	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-5-1886	9. AGE (In years last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Quincy, Illinois	
13a. FATHER'S NAME Charles T. Magnuson			13b. MOTHER'S MAIDEN NAME Nellie Unknown	14. NAME OF HUSBAND OR WIFE Jessie Lee Magnuson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Jessie Lee Magnuson Weaubleau, Mo.		ADDRESS
12. CITIZEN OF WHAT COUNTRY? U.S.A.				

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Complete Paralysis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Stroke Apoplexy DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?
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22. I hereby certify that I attended the deceased from 1949 to July 26, 1954 that I last saw the deceased alive on July 25, 1954 and that death occurred at 8 A m., from the causes and on the date stated above.

23a. SIGNATURE H. R. Easton	(Degree or title)	23b. ADDRESS 4607 Weaubleau Mo	23c. DATE SIGNED July 29, 1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-29-54	24c. NAME OF CEMETERY OR CREMATORY Robinson Cemetery	24d. LOCATION (City, town, or county) (State) St. Clair County Mo.
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DATE REC'D BY LOCAL REG. 7.30.1954	REGISTRAR'S SIGNATURE Mary Johnson	464-0	25. FUNERAL DIRECTOR'S SIGNATURE Beckwith Funeral Home	ADDRESS Humansville,
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Humansville, 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.