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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7898

State File No. ....

FILED APR 4 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5460 Registrar's No. 275

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rogersville-R2</u>		c. CITY OR TOWN <u>Rogersville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>Life</u>		f. STREET ADDRESS (If rural, give location) <u>Route 2 - Clay township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clay township</u>			

3. NAME OF DECEASED a. (First) <u>Marion</u> b. (Middle) <u>- Eugene</u> c. (Last) <u>- Osborn</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March-26-1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 31-1940</u>	9. AGE (In years last birthday) <u>14</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Greene County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Francis Marion Osborn</u>	13b. MOTHER'S MAIDEN NAME <u>Flossie Wolfe</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>3</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Marion Francis Marion Osborn</u>	ADDRESS <u>Rogersville, Mo R-2</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Act. Skull</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Road</u>	21c. CITY, TOWN OR VILLAGE <u>Clay Township</u> (COUNTY) <u>Springfield</u> (STATE) <u>Greene</u> <u>Mo</u>
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 26, 1955 7p</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Following cable wrapped around tractor wheel</u> <u>Tractor tipped over</u>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, 7 p. m., from the causes and on the date stated above.

23a. SIGNATURE OF PHYSICIAN <u>Dr. E. Allen Prekens, M.D.</u> (Degree or title) <u>3</u>	23b. ADDRESS <u>Springfield, Mo</u>	23c. DATE SIGNED <u>3-28-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 29-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Galloway Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Galloway-Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>3-28-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ray L. Lamer</u>	ADDRESS <u>Springfield, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 331

P. O. Address Springfield

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.