

THE REPUBLIC OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36010**
Registrar's No. **8607**

FILED OCT 18 1956

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Mo	b. COUNTY St. Louis
c. LENGTH OF STAY (in this place) 4 days		c. CITY OR TOWN Bellefontaine Neighbors 4000	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		e. STREET ADDRESS (If rural, give location) 9718 Durham Dr.	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) William	b. (Middle) S.	c. (Last) Osborn	(Month) (Day) (Year) Sept. 16 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 31 1881
9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	11. BIRTHPLACE (City and State or Foreign Country) Newburg Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George W. Osborn	13b. MOTHER'S MAIDEN NAME Mary Williams	14. NAME OF HUSBAND OR WIFE Marie Osborn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 707 05 7498	17. INFORMANT'S SIGNATURE OR NAME Catherine Clooney ADDRESS 9718 Durham Dr.

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332X		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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 **7/1**, 19**49**, to **9/16**, 19**56**, that I last saw the deceased alive on **9/16**, 19**56**, and that death occurred at **0 A** m., from the causes and on the date stated above.

23a. SIGNATURE Albert S. ... (Degree or title)	23b. ADDRESS 321 N. ...	23c. DATE SIGNED 9/17/56
24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE 9/19/56	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. SEP 18 1956	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Buchholz Mortuary ADDRESS 5967 W. Florissant
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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.....
Signature of Student Embalmer

Signed *Walter J. Zwick*.....

Licensed Embalmer No. *453*.....

P. O. Address *St. Louis*.....

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.