

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001138

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 12

1. PLACE OF DEATH
a. COUNTY Howard
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Mo Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Whitlow Rest Home Length of stay in lb 10 mo.
2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before)
a. STATE Missouri b. COUNTY St Charles
c. CITY OR TOWN St Charles, Mo Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) County Farm Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
MARY GILL OSBORN
4. DATE OF DEATH Month Day Year
Feb. 1, 1959

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED NEVER MARRIED
WIDOWED DIVORCED
8. DATE OF BIRTH Sept. 30, 1878
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR OCCUPATION Self Employed
11. BIRTHPLACE (City and state or country) Unknown
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Sam Osborn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Howard Co. Welfare Office Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pulmonary edema
DUE TO (b) cardiac decompensation
DUE TO (c) arteriosclerotic heart disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200
INTERVAL BETWEEN ONSET AND DEATH
1 wk
3 months
indeterminate

20a. ACCIDENT SUICIDE HOMICIDE natural
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm J. Shaw, Jr M.D.
22b. ADDRESS Lee Hospital, Fayette, Mo
22c. DATE SIGNED 2-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/4/59
23c. NAME OF CEMETERY OR CREMATORY Fayette City Cemetery
23d. LOCATION (City, town, or county) (State) Fayette, Missouri

24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo
25. DATE RECD. BY LOCAL REG. 2-5-59
26. REGISTRAR'S SIGNATURE Mary K. Shell

300
1-57 4

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Donald L Roberts*

Licensed Embalmer No. *4722*

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