

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

-60-032700

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7649** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>18 Yrs,</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>E/R to City Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1823 S. 13th</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>SAM</b> Middle <b>OSBORNE</b> Last			4. DATE OF DEATH Month <b>Aug.</b> Day <b>2,</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/1900</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Pontotoc, Miss.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Ruby Osborne</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>	16. SOCIAL SECURITY NO. <b>494070078</b>	17. INFORMANT Address <b>Ruby Osborne, 1823 S. 13th, St. Louis</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO (b) <b>Intermittent Hypertension</b> DUE TO (c) <b>594x</b>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at **12 13 AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>James M. Smith, M.D.</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>8-3-60</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/4/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jeff. Brk's., Mo.</b>
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24. FUNERAL DIRECTOR <b>McLaughlin, 2301 Lafayette (4)</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 3 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed

*Samuel R. Chapman*

Licensed Embalmer No. 45

P.O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.