

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. Calloway Jr.

-62-001222

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 177

STATE FILE NUMBER

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 10 YRS.	c. CITY OR TOWN SPRINGFIELD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2113 W. NICHOLS
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last OSBORNE			4. DATE OF DEATH Month JAN. Day 29 Year 1962		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/15/98	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) EAST POINT, KY.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME THOMAS E. OSBORNE		13b. MOTHER'S MAIDEN NAME AMANDA GREER		14. NAME OF HUSBAND OR WIFE REBECCA OSBORNE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. # 1		16. SOCIAL SECURITY NO. NO	17. INFORMANT Address REBECCA OSBORNE, SPRINGFIELD, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Chronic Pyelonephritis		2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Paralysis Agitans	30 yrs
	DUE TO (c) Acute encephalitis	44 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

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.)	
20c. TIME OF INJURY Hour a.m. p.m.	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
21. I attended the deceased from March 1960 to Jan 29, 62 and last saw him alive on Jan 29, 62 Death occurred at 12:10 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Calloway Jr. MD		22b. ADDRESS Springfield Mo	22c. DATE SIGNED 30 Jan 62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/1/62	23c. NAME OF CEMETERY OR CREMATORY NATIONAL	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 2-2-62	26. REGISTRAR'S SIGNATURE Effie G. Melton

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 8 1962

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 *R. L. M. O. O'Brien*

Licensed Embalmer No. 2727

P. O. Address *1000 ...*

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.