

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-024314

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 38

FILED JUL 10 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Length of stay in 1b Years <u> </u>	c. CITY OR TOWN <u>Osceola</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Medical Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John C. Osburn</u>			4. DATE OF DEATH Month Day Year <u>June 21, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aircraft Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>67</u>
11a. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Corbit Osburn</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Belle Clifton</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Ann Osburn</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		17. INFORMANT Address <u>3 Ruth Ann Osburn, Osceola Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>			
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 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. Month, Day, Year	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 <u>June 19-62</u> to <u>June 21-62</u> and last saw him alive on <u>6-21-62</u> Death occurred at <u>7:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ruth Seewers MD</u> (Degree or title)		22b. ADDRESS <u>Osceola Mo.</u>	22c. DATE SIGNED <u>6-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6/25/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>	23d. LOCATION (City, town, or county) (State) <u>Osceola Mo.</u>
24. FUNERAL DIRECTOR <u>Goodrich Funeral Home, Osceola Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-24-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul Hunter

Licensed Embalmer No. 3990

P. O. Address Orcola, 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.