

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047496

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 166

FILED JAN 4 1963

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Johnson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u> Length of stay in lb <u>10 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warrensburg Med. Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Johnson</u> c. CITY OR TOWN <u>Warrensburg</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Pleasant View Rest Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Orvin</u> Middle <u>MUNSON</u> Last <u>OSBORNE</u>			<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>19</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-6-1882</u>	<b>9. AGE (last birthday)</b> <u>80</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Editor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Newspaper</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Grundy Co Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Loche Byron Osborne</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mellie Minor</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mayme Cox</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NI</u>			<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Charles R Osborne 308 Lincoln</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia bilateral</u>		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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
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<b>20c. TIME OF INJURY</b> Hour <u>  </u> s.m. <u>  </u> p.m. <u>  </u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from 15 Dec 62 to 19 Dec 62 and last saw her/him alive on 19 Dec 62  
 Death occurred at 9:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>W. S. Tolson M.D.</u>	<b>22b. ADDRESS</b> <u>Warrensburg, Mo.</u>	<b>22c. DATE SIGNED</b> <u>12-21-62</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>12-21-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Stockton Cem</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Stockton Mo</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Sidman &amp; Dunning Clinton</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>Mo Dec 21, 1962</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Barbara C. Cuthfield</u>
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JAN 7 1963

**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 Robert L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.