No. 2
11-10-39
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X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 16636

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4114

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Pacific Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pettis

(c) City or town Sedalia NR (If outside city or town limits, write "RURAL")

(d) Street No. 511 E 3rd St (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jack Lawrence Osborne 216

3. (b) If veteran, name war No

3. (c) Social Security No. 702-16-3112

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dollie

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Oct. (Month) 11 (Day) 1885 (Year)

8. AGE: Years 54 Months 6 Days 24 If less than one day hr. min.

9. Birthplace Chicago (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Boiler Maker

11. Industry or business Railroad

FATHER 12. Name Unknown

13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dollie Osborne

(b) Address Sedalia, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-7-40 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 7 1940 (Date received local registrar) (b) J. B. Burdick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 5th year 1940 hour 9 minute 54 P.M.

21. I hereby certify that I attended the deceased from May 3rd, 1940 to May 5, 1940; that I last saw him alive on May 5, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage.

Due to Hypertension.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. A. J. Lasito (M. D. ~~or other~~)

Address Mo-Pac. Hosp. Date signed 5-5-40

(Licensed Embalmer's Statement on Reverse Side)

JAN 11 1955

DEC 10 1954

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1861

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**