

No. 2
11-10-39
5-17-39
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FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3183**

Registration District No. **471**

Primary Registration District No. **4284**

Registrar's No. **5**

5
4
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Lawrence

(a) County Lawrence

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

(c) Name of hospital or institution:
213 West Washington Ave
(If not in hospital or institution, write street number or location)

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

In this community 57 Yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence

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

(d) Street No. 213 West Washington Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Margaret Osborn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16 year 1941 hour 4.15 minute a M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife George Osborn 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. I 1856
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 10 1941 to Feb 6th 1941;
that I last saw him alive on Feb 5th 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months 5 Days 5 If less than one day _____ hr. _____ min.

Immediate cause of death Hypertatic Pneumonia **Duration** 5 days

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

Due to Posture (on back) and an old endo-myocarditis **Duration** 2 wks 15 yrs

10. Usual occupation Housewife

Due to Chronic Arthritis **Duration** 15 yrs

11. Industry or business _____

Other conditions Chronic Arthritis **PHYSICIAN** _____
(Include pregnancy within 3 months of death)

12. Name unknown

Major findings: No operation **Of operations** _____

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

Of autopsy No one made

14. Maiden name unknown

Underline the cause to which death should be charged statistically.

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

16. (a) Informant Harry Osborn
(b) Address Pierce City

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

17. (a) burial (b) Date thereof 28 41
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation City Cemetary

(b) Date of occurrence _____

18. (a) Signature of funeral director Henry Clark
(b) Address Pierce City Mo.

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

19. (a) Feb. 7 (b) E B Wright
(Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? if 22

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature H. Row Clark (M. D. or other) D
Address Pierce City, Mo. Date signed 2/16/41

RECEIVED

District Health Officer No. 6,
District File Number 241-262

Date Filed FEB 11 1941

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.....

[Signature]
....., Registered Apprentice No.....
working under my personal supervision.

Signed *[Signature]*

Licensed Embalmer No. 3827

P. O. Address *[Signature]*

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.