

Filed **JAN 13 1943**
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10921**
10923

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**

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

(c) Name of hospital or institution: **Homer Phillips Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **28 days**
(Specify whether years, months or days)

In this community **13 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**, (b) County **000**

(c) City or town **St. Louis**,
(If outside city or town limits, write "RURAL") **1017**

(d) Street No. **2931 Garrison**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Edward Osborne**

3. (b) If veteran, name war **3. (c) Social Security** No. **0**

4. Sex **Male** **5. Color or race** **Colored** **6. (a) Single, widowed, married,** **2 divorced** **Widower**

6. (b) Name of husband or wife **6. (c) Age of husband or wife if** **Unknown** **alive** **years**

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	about 78			hr. min.

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

10. Usual occupation **Nil**

11. Industry or business

12. Name **Alfred Osborne**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country) **9**

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country) **9**

16. (a) Informant **Shirley M. Smith**
(b) Address **2601 N. Whittier St.**

17. (a) Place: burial or cremation **Washington D.C.**
(Burial, cremation, or removal) **(b) Date thereof** **12-4-42**
(Month) (Day) (Year)

18. (a) Signature of funeral director **W. R. ...**
(b) Address **3502 ...**

19. (a) DEC 29 1942 **(b) J. F. ...**
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **2**, year **1942** hour **8** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **November 4**, 19 **42** to **December 2**, 19 **42**; that I last saw him alive on **December 2**, 19 **42**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease with Decompensation**
Duration **Unknown**

Due to **92%**
Due to **92%**
Other conditions **92%**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **Of operations**
Of autopsy
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?

While at work? **(Specify type of place)**
Means of injury **9**

23. Signature **A. E. Smith** **(M. D. or other)**
Address **2601 N. Whittier** **Date signed** **12/4/42**

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

MOTHER FATHER

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.....

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, fact should be so stated above.