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20712

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 11 1945

Registration District No. 191

Primary Registration District No. 5-639

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Rural - Washington Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
10 mi. S.E. Odessa Mo.
(If not in hospital or institution, write street number or location)

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

In this community 37 yr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town 10 mi. S.E. Odessa Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Rural - Washington - Township
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Low Belle Osborn

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9th
year 1945 hour 10 minute 4 A.M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife C.W. Osborn

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased: June (Month) 15 (Day) 1871 (Year)

21. I hereby certify that I attended the deceased from Mar 22 1945 to June 7 1945

that I last saw her alive on June 7 1945 and that death occurred on the day and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

Immediate cause of death: Hemiplegia (Paralysis of right side)

Due to cerebral hemorrhage

with hypertension & nephritis

and mitral regurgitation

for several years

9. Birthplace Lafayette Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

Other conditions for several years
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER { 12. Name Ruben Smith

13. Birthplace Cooper Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Marian Buchanan

15. Birthplace St. Louis - Scotland
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Edna Osborn

(b) Address Odessa Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 11 45
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Taber Cem.

18. (a) Signature of funeral director Edna Osborn

(b) Address Odessa Mo.

19. (a) July 2 - 1945 (Date received local registrar) (b) Mrs. W.F. Baker (Licenar's signature)

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)

(e) Means of injury _____

23. Signature R. C. Chasley (M. D. or other) _____

Address Odessa Mo. Date signed 6/11/45

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

1157

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

7/12/45

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 Clifton A. Blisore
Licensed Embalmer No. 2945
P. O. Address Adrian 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 this body is not embalmed, fact should be so stated above.

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3-45
443880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 270

Registration District No. 111

Primary Registration District No. 5629

1. PLACE OF DEATH

(a) County Lafayette
(b) City or town Prudt Washington Fin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME

Lou Belle Osborn

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced _____
race _____

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

7. Birth date of deceased: June (Month) 1 (Day) 1905 (Year)

8. AGE: Years 73 Months 11 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 1 Year 1965 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to chronic nephritis
Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (e) Means of injury _____

23. Signature R Osborn (M. D. or other) _____ Date signed 7/14/65

SUPPLEMENTARY

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

20712