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DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED MAY 22 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19219

State File No. _____

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **4653**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 3 days
(Specify whether life years, months or days)

3. (a) PRINT FULL NAME James W. Osborn

3. (b) If veteran, name war World War I

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Marie

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased: March 2 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>2</u>	<u>4</u>	hr. /min.

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

10. Usual occupation News Vendor

11. Industry or business:

12. Name Jease Osborn

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

14. Maiden name Anna Gwinn

15. Birthplace New Malden Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Osborn

(b) Address 10 North 10th St.

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof 5-9-47
(Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director John L. Ziegenhein & Sons

(b) Address 7027 Gravois

19. (a) (Date received local registrar) MAY 8 - 1947 (b) J. F. Bredeek
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 10 North 10th St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1947 hour 11 minute 45 A.M.

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

Immediate cause of death: Internal hemorrhage from ruptured liver in front of ribs when struck by automobile being driven by one Harold Walter Hausert Jr. on home of 3133 22nd Street, East St. Louis 3-404-M - May 4th 1947

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy 16

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) Accident

(b) Date of occurrence May 4, 1947 in St. Louis

(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?
Public Street

23. Signature of physician Patrick E. DeGalaris, M.D.
Address 1300 Clark Date signed 5-8-47

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 *Frank J. Quorn*

Licensed Embalmer No. *2245*

P. O. Address *St. Louis, 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.