

FILED JAN 26 1951

STANDARD CERTIFICATE OF DEATH

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**State File No. **3074**Registrar's No. **299**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Crocker 0850	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) /	
3. NAME OF DECEASED (Type or Print) a. (First) Priscella		b. (Middle) Jane	
		c. (Last) Timmons	
		4. DATE OF DEATH (Month) (Day) (Year) 1 10 51	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 2, 1900	
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Kentucky /		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John C. Osborn		13b. MOTHER'S MAIDEN NAME Sarah Ella Yonce	
14. NAME OF HUSBAND OR WIFE Alfred Eugene		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 496-07-2991		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alfred E. Timmons, Crocker, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombophlebitis, left leg DUE TO (c) Obesity	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. INTERVAL BETWEEN ONSET AND DEATH 7 hours		19d. INTERVAL BETWEEN ONSET AND DEATH 12 days	
19e. INTERVAL BETWEEN ONSET AND DEATH 30 years		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H102X	
22. I hereby certify that I attended the deceased from 1-1 , 19 51 , to 1-10 , 19 51 , that I last saw the deceased alive on 1-10 , 19 51 , and that death occurred at 10:07a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) F. Bradley M.D.		23b. ADDRESS Barnes Hospital	
23c. DATE SIGNED 1-10-51		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 1-11-51		24c. NAME OF CEMETERY OR CREMATORY City	
24d. LOCATION (City, town, or county) (State) Crocker, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
DATE REC'D BY LOCAL REG. JAN 11 1951		REGISTRAR'S SIGNATURE J. B. Farahan	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Signed.....
Student Embalmer

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.