S. No. 300
v. 10.48

FILED MAR 23 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7890

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4169 Registrar's No. 14

0320

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

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osborne
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: DeKalb
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osborne 0320
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print): E
a. (First): James
b. (Middle): Edwin
c. (Last): Daniel

4. DATE OF DEATH (Month) 3 (Day) 10 (Year) 52

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: ~~Sx~~ I-10-1858
9. AGE (In years last birthday): 94 — If under 1 year: Months 3, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: XXXXX
11. BIRTHPLACE (State or foreign country): Mo, 0
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Edwin Daniel
13b. MOTHER'S MAIDEN NAME: Lena Skinner
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): , , , , ,
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Mrs A?L, Perry Osborne — ADDRESS: 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, Fractured rib, Laceration of scalp & face — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fall down stairs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 032 E 9000 — 21
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Osborn DeKalb Mo.
21d. TIME OF INJURY (Month) 3 (Day) 10 (Year) 52 (Hour) 6:30 pm
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Fall down basement stairs

22. *I hereby certify that I attended the deceased from* 3-10-52, 1952, *to* only, 19__, *that I last saw the deceased alive on* 3-10, 1952 *and that death occurred at* 6:30 pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Witten Mo
23b. ADDRESS: Cameron Mo
23c. DATE SIGNED: 3-20-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 3-14-52
24c. NAME OF CEMETERY OR CREMATORY: Fairport
24d. LOCATION (City, town, or county) (State): Fairport Mo

DATE REC'D BY LOCAL REG.: 3-20-52
REGISTRAR'S SIGNATURE: Roscoe Davidson 82
25. FUNERAL DIRECTOR'S SIGNATURE: John [signature] — ADDRESS: Maysville

(Licensed Embalmer's Statement on Reverse Side)

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.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3933

P. O. Address Maysville 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.