

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4080

State File No. _____

BIRTH NO. FILED FEB 23 1954 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Andrew</u>	
b. CITY OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural R.F.D. 2, SAVANNAH</u>	
c. LENGTH OF STAY (In this place) <u>8 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>80 1/2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>mercy Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jessie</u> b. (Middle) <u>Donald</u> c. (Last) <u>OSBORN OSBURN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-12-1954</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-30-1909</u>	9. AGE (In years last birthday) <u>44</u>	10. IF UNDER 1 YEAR Days <u>1</u> Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>John Osborn Osburn</u>	13b. MOTHER'S MAIDEN NAME <u>Georgia Lee</u>	14. NAME OF HUSBAND OR WIFE <u>anna Osburn</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Anna Osburn</u> ADDRESS <u>R.F.D. 2, SAVANNAH Mo</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Degeneration</u>		<u>8 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mitral Stenosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Coronary insufficiency</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>410X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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?

22. I hereby certify that I attended the deceased from April 14, 1947, to Feb. 12, 1954, that I last saw the deceased alive on Feb. 11, 1954, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W.S. Maxwell</u>	23b. ADDRESS <u>207 W. Main, Savannah, Mo.</u>	23c. DATE SIGNED <u>2/13/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2-16-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>	24d. LOCATION (City, town, or county) (State) <u>SAVANNAH Mo</u>
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DATE REC'D BY LOCAL REG. <u>Feb 15, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u> <u>485-</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Breit Funeral Home SAVANNAH Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed..... *E. C. Brit*

Licensed Embalmer No. *2630*

P. O. Address. *Savannah 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.