

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33946**
Pk **9148**
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge		d. STREET ADDRESS (If rural, give location) 3863 West Pine	

3. NAME OF DECEASED (Type or Print) Clifford a. (First) b. (Middle) - c. (Last) Osborne			4. DATE OF DEATH (Month) (Day) (Year) 9 30 57		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apartment house		8. DATE OF BIRTH 1-9-1909	
				9. AGE (In years last birthday) Months Days Hours Min. 48	
11a. BIRTHPLACE (City and State or Foreign Country) Stigler, Oklahoma			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME William Osborne		13b. MOTHER'S MAIDEN NAME Joanna Crain		14. NAME OF HUSBAND OR WIFE Minnie	
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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) No		16. SOCIAL SECURITY NO. +88-10-2562		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Minnie Osborne, 3863 W. Pine	
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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, asphyxia, 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) Epidermoid carcinoma of esophagus					
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None DUE TO (c) None					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None						

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 2 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept. 28, 1957, to Sept. 30, 1957, that I last saw the deceased alive on Sept. 29, 1957, and that death occurred at 6:20A m., from the causes and on the date stated above.

23a. SIGNATURE Victor Paul Johnson M.D. (Degree or title)	23b. ADDRESS 1325 S. Grand Blvd	23c. DATE SIGNED 9-30-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-2-1957	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. OCT 1 57	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin's, 2301 Lafayette
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed James R. Chapman

Licensed Embalmer No. 1550

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.