

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46177
STATE FILE NUMBER
12302
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b #1.	d. STREET ADDRESS (If outside, give location) 1722 a So.7th Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EMERY Basil OSBORNE			4. DATE OF DEATH Month Day Year DEC. 21, 1957		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 12 1894	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loader	10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (City and state or country) Clinton Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Allen Osborne	13b. MOTHER'S MAIDEN NAME Elsie McAfee	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT Olivette Graves 4511a So. Grand	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 36 HRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ESOPHAGEAL VARICES	
	DUE TO (c) LAENNEC'S CIRRHOSIS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5811		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 12/3/57 to 12/2 1/57 and last saw her alive on 12/21/57 Death occurred at 6:08 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Robert Z. Owen, M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 12/23/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec 24 57	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus	23d. LOCATION (City, town, or county) (State) St. Louis Cty Mo.
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24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. DEC 23 57	26. REGISTRAR'S SIGNATURE Carl Smith MD
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *Thomas R. Senwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.