

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017978

FILED VS APR 25 1960 324

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 81

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>65 yrs.</u>		c. CITY OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fields Boarding House</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>452 W Morgan</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>IDA</u> Last <u>SOLOMON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-7-1869</u>		9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (City and state or country) <u>Randolph Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Tyler Osborn</u>				13b. MOTHER'S MAIDEN NAME <u>Ruth Lambert</u>				14. NAME OF HUSBAND OR WIFE <u>X</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT Address <u>Marshall</u> <u>Mrs. Sue Osborn 657 W Porter</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Under 1 yr</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown					
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.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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					
21. I attended the deceased from <u>April 10 - 1960</u> to <u>April 19 - 60</u> and last saw her ^{him} alive on <u>April 19, 1960</u> Death occurred at <u>6 AM, April 21 - 60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>C. L. Loupes M.D.</u>						22b. ADDRESS <u>Marshall, Missouri</u>			22c. DATE SIGNED <u>4-23-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-23-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>						
24. FUNERAL DIRECTOR <u>Sweeney-Reser Funeral Home, Marshall</u>				ADDRESS <u>4-23-60</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Cecil A. Reed</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 13 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Jack M. Rose

Licensed Embalmer No. 4643

P. O. Address Marsha

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.