

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

370-62-004311
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

AMENDED

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>4385 Maryland Avenue</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSIE ELIZABETH OSBORN</u>			4. DATE OF DEATH Month Day Year <u>January 9 1962</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1868</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>New York, New York</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joseph P. Byrne</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Low</u>		14. NAME OF HUSBAND OR WIFE <u>William Harvey Osborn</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>no</u>		17. INFORMANT Address <u>Robert R. Osborn, 225 Nancy Place Ferguson 35, Mo.</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>Arteriosclerosis Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____		<u>42:00</u>
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 checked="" type="checkbox"/> No <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>9-19-64</u> to <u>1-9-62</u> and last saw her <u>alive</u> on <u>1/9/62</u> Death occurred at <u>12:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>R. Hayden MD</u>	22b. ADDRESS <u>730 Hodiamouth</u>	22c. DATE SIGNED <u>1-9-62</u>
---	---------------------------------------	-----------------------------------

23b. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>1-10-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Metairie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Orleans, Louisiana</u>
---	-------------------------------	--	--

24. FUNERAL DIRECTOR <u>C. R. Lupton & Sons-St. Louis 30, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 9 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>
--	---	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 9 STATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

Dr. L. F. Hayden
730 Hollimont
Tue: Hrs 1-3

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 Arnold W. Schoene

Licensed Embalmer No. 3864

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.