MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County: Cole

Township: Marion or Village or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 211

File No. 24, 5E

Primary Registration District No. 5291

Registered No. 31296

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Anna La Verne Osick

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	single

DATE OF BIRTH: April (Month) 23 (Day), 1919 (Year)

AGE: 1 yrs. 5 mos. 26 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: not working

(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): McGirk Mo

PARENTS

NAME OF FATHER: Henry Frederick Osick

BIRTHPLACE OF FATHER (City or town, State or foreign country): Moniteau Co Mo

MAIDEN NAME OF MOTHER: Lydia Helen Schull

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Moniteau Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lydia Helen Osick

(ADDRESS) McGirk Mo

Filed 10/18/ 1920 Joe N. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 17 (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 10, 1920, to Oct 17, 1920, that I last saw her alive on Oct 17, 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

118B

104

(Duration) ____ yrs. ____ mos. 8 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) B F Bagby M. D.

Oct 18, 1920 (Address) Centertown Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Salem German Church

DATE OF BURIAL: 10/18/ 1920

UNDERTAKER: Jack Bowlin

ADDRESS: Centertown

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PLACE OF DEATH

County ________

Township ________ Registration District No. ________ File No. ________
or
Village ________ Primary Registration District No. ________ Registered No. ________
or
City ________ (NO. ________ St.; ________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ________

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX ___ / COLOR OR RACE ___ / SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) ___	DATE OF DEATH ________ (Month) ________ (Day), 191___ (Year)
DATE OF BIRTH ________ (Month) ________ (Day), 1___ (Year)	I HEREBY CERTIFY, that I attended deceased from ________, 191___, to ________, 191___,
AGE ___ yrs. ___ mos. ___ ds. / If LESS than 1 day, ___ hrs. or ___ min.?	that I last saw h___ alive on ________, 191___, and that death occurred, on the date stated above, at ___ m. The CAUSE OF DEATH* was as follows:
OCCUPATION (a) Trade, profession, or particular kind of work ________	________
(b) General nature of industry, business, or establishment in which employed (or employer) ________	________
BIRTHPLACE (City or town, State or foreign country) ________	________ (Duration) ___ yrs. ___ mos. ___ ds.
PARENTS: NAME OF FATHER ________	Contributory (SECONDARY) ________ (Duration) ___ yrs. ___ mos. ___ ds.
PARENTS: BIRTHPLACE OF FATHER (City or town, State or foreign country) ________	(Signed) ________ M. D.
PARENTS: MAIDEN NAME OF MOTHER ________	________, 191___ (Address) ________
PARENTS: BIRTHPLACE OF MOTHER (City or town, State or foreign country) ________	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
(Informant) ________	Where was disease contracted if not at place of death? ________
(ADDRESS) ________	Former or usual residence ________
Filed ________, 191___, ________ REGISTRAR	PLACE OF BURIAL OR REMOVAL ________ / DATE OF BURIAL ________, 191___
	UNDERTAKER ________ / ADDRESS ________

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