

**FILED SEP 1 1945**  
Registration District No. **149**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Jackson

(a) County **Kansas City**

(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **300 South Drury St. K.C. Mo.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None** (Specify whether)

In this community **32 Years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 48**

(c) City or town **Kansas City** ?  
(If outside city or town limits, write "RURAL")

(d) Street No. **300 South Drury St.** 8  
(If rural, give location)

(e) Citizen of foreign country? **No.** 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MATTIE EMMA OSBORN**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female** / 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **J.J. Osborn**

6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **Feb. 4 th, 1872**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **21 st**  
year **1945** hour **8** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **Aug 11, 1945** to **Aug 21, 1945**  
that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration \_\_\_\_\_

8. AGE: Years **73** Months **6** Days **26 17** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to **General Arteriosclerosis**

Due to **Chronic Myocarditis**

9. Birthplace **Hopkinsville Ky.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business **Home**

12. Name **John Adams**

13. Birthplace **Unknown Ky.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Ellen Thompson**

15. Birthplace **Unknown Ky.**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations **93 2**

Of autopsy **No**

Underline the cause to which death should be charged statistically.

16. (a) Informant **J.J. Osborn**

(b) Address **300 South Drury, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **8/24/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington Cem.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director **Melody-McGilley-Eyl**  
(b) Address **1800 Linwood Blvd. K.C. Mo.**

19. (a) **8-23-45** (b) **Sheraldine Holmes**  
(Date received local registrar) (Registrar's signature)

23. Signature **Edward C. Littel** (M. D. or other) \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

Address **1040 Argyle Bg** Date signed **Aug 29/45**

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*[Handwritten Signature]*  
.....  
Licensed Embalmer No. *2999*  
*KC*

P. O. Address.....

**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.**