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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 20 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36790

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4188

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
1020 West 57th Terrace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether
In this community 45 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1020 West 57th Terrace, 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Albert P. Osborn

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife unknown, 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased December 11 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 1 day 1st
year 1948 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from Feb 12
1940 to November 1, 1948
that I last saw him alive on October 31, 1948
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

78	10	20	hr. min.
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Immediate cause of death

acute congestive cardiac failure 1 day

Due to aortic valvular incompetency - 8 years

Due to arteriosclerotic aortic degeneration 12 years

Other conditions cardiac hypertrophy 7 years
(Include pregnancy within 3 months of death)

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation General Agent

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER {

11. Industry or business Life Insurance Company

12. Name William Osborn 9

13. Birthplace unknown, (City, town, or county) (State or foreign country)

14. Maiden name Philena Campbell

15. Birthplace unknown, (City, town, or county) (State or foreign country)

16. (a) Informant Lee H. Griffin

(b) Address Chicago, Illinois

17. (a) burial (b) Date thereof 11-3-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Moriah Tempel

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 Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 11-3-48 (Date received local registrar) Geraldine Holmes (Registrar's signature)

Graham Asher (Specify type of place) 1020
While at work? (2) Means of injury _____

23. Signature Graham Asher (M. D. or other) MD
Address 1220 Professional Bldg Date signed 11-1-48

Dr. Graham Asher

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.....

Robert H. Reed

Licensed Embalmer No. *3745*

P. O. Address..... *H. C. No.*

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.