

FILED JUL 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23899

STATE FILE NUMBER

2340

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City 3348 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2607 Garfield Length of stay in lb 25yrs		d. STREET ADDRESS (If outside, give location) 2607 Garfield Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle M. Last Osborne			4. DATE OF DEATH July 3, 1956 Month July Day 3 Year 1956
5. SEX female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 3, 1906
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY private family	11. BIRTHPLACE (City and state or country) Atoka, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Osborne	
14. MOTHER'S MAIDEN NAME Annie E. Scott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 499-14-3397		17. INFORMANT Vivian Bryant Address 2607 Garfield	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cononary Thrombosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH 4201
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	
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 6-18-56 to 7-2-56 and last saw her/him alive on 7-2-56 Death occurred at 4 AM m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Deborah L. Dixon MD (Name or title)		22b. ADDRESS 2204 1/2 East 18th, Street	
22c. DATE SIGNED 7-6-56		23a. BURIAL, CREMATION, REMOVAL (Specify) removal	
23b. DATE July 8, 1956		23c. NAME OF CEMETERY OR CREMATORY Haskell, Oklahoma	
23d. LOCATION (City, town, or county) (State) Haskell, Oklahoma		24. FUNERAL DIRECTOR Watkins Bros. 18th + Benton ADDRESS _____	
25. DATE RECD. BY LOCAL REG. 7-6-56		26. REGISTRAR'S SIGNATURE Neva Minshell	

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Bruce P. Watkins*.....

Licensed Embalmer No. *45*.....

P. O. Address *18th Ave*.....

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.