

Health, Welfare
Public Service

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32083

STATE FILE NUMBER 4213

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

300
-57

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 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Linwood Nursing Home, 1900 Linwood Blvd		Length of stay in lb 50 yrs	d. STREET ADDRESS (If outside, give location) 1900 Linwood Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LETTA OSBORN		First Middle Last	4. DATE OF DEATH Month Day Year Sept. 11 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 4 - 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part Owner		10b. KIND OF BUSINESS OR INDUSTRY Foresty Hotel	9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) Attony Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Russel Scott Osborn		13b. MOTHER'S MAIDEN NAME Sabrina Fellicia	14. NAME OF HUSBAND OR WIFE None
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. None	17. INFORMANT E. J. Schmidt Address Kansas City, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardosis DUE TO (c) Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 wk yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4221			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 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 yes to 9-11-57 and last saw her alive on 8-28-57 Death occurred at a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John O. Skinner M.D.		22b. ADDRESS 1102 Grand Ave	22c. DATE SIGNED 9/11/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-12-57	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Stoeter Kansas
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 9-11-57	26. REGISTRAR'S SIGNATURE neva munsell

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

John O. Skinner

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. O. Skinner
Bryant Bldg

10/11:30PM

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 *J. O. Skinner*

Licensed Embalmer No. *2197*

P. O. Address *KB*

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.