

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35101**

FILED OCT 16 1957

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **143**

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Harrisonville		c. CITY OR TOWN Harrisonville	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 40 yrs		e. STREET ADDRESS (If rural, give location) 205 W Pearl	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION W Pearl			

3. NAME OF DECEASED (Type or Print)	a. (First) Jesse	b. (Middle) Ezekiel	c. (Last) Osborn	4. DATE OF DEATH (Month) Oct (Day) 3 (Year) 1957
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 14 1872	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman	10b. KIND OF BUSINESS OR INDUSTRY Poultry	11. BIRTHPLACE (City and State or Foreign Country) Hiawasse, Georgia	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Samuel J. Osborn	13b. MOTHER'S MAIDEN NAME Lilian Brown	14. NAME OF HUSBAND OR WIFE Pink Osborn
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO	16. SOCIAL SECURITY NO. 495 24 3235	17. INFORMANT'S SIGNATURE OR NAME Mrs. Joann Payne Latour, Missouri	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Sudden
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Atherosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **March 1954**, to **Oct 3, 1957**, that I last saw the deceased alive on **Oct 2, 1957**, and that death occurred at **4 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Type or title) Edwards James M.D.	23b. ADDRESS Harrisonville, Mo	23c. DATE SIGNED 10-6-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 6, 1957	24c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	24d. LOCATION (City, town, or county) (State) Harrisonville, Missouri
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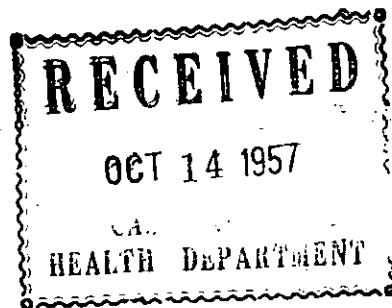
DATE REC'D BY LOCAL REG. Oct 6, 1957	REGISTRAR'S SIGNATURE Dora Barward	FUNERAL DIRECTOR'S SIGNATURE William Dickey Harrisonville, Mo	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

4570

OCT 23 1957



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 *Robert Atkinson*

Licensed Embalmer No. *4902*

P. O. Address *San Francisco, Ca.*

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.