

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023603
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6740

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hosp.		d. STREET ADDRESS (If outside, give location) 4927 Robert Ave.	

3. NAME OF DECEASED (Type or print) First JAMES Middle C. Last OSBORN SGT.			4. DATE OF DEATH Month July. Day 3, Year 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1903	9. AGE (In years last birthday) 55	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) Sgt.	10b. KIND OF BUSINESS OR INDUSTRY Police Dept.	11. BIRTHPLACE (City and state or country) Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Osborn	13b. MOTHER'S MAIDEN NAME Lulu Unknown	14. NAME OF HUSBAND OR WIFE Emma R. Osborn
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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.	17. INFORMANT Address Emma Osborn-4927 Robert Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Expanding Astrocytoma of Brain		INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)	193.0	
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Progressive Paralysis. Probably terminal Pneumonia		19. WAS AUTOPSY PERFORMED? 2 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.)
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20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from May 27, 1958 to July 3, 1958 and last saw him alive on July 3, 1958 Death occurred at 11:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joshua L. Jensen, M.D. (Degree or title)	22b. ADDRESS 607 N. Grand Blvd.	22c. DATE SIGNED July 7, 1958
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 7, 1958	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Kriegshauser-4228 S. Kingshighway ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 7 58	26. REGISTRAR'S SIGNATURE Carl Smith Mo
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Richard W. Stoverson*

Licensed Embalmer No. 4007.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.