

t. Health,
, & Welfare
s. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024575

STATE FILE NUMBER

FILED JUL 28 1958

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 319

S. 300
v. 1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Boone | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Shelby | |
| b. CITY OR TOWN Columbia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Shelbina 1020 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY of Mo. Medical Center Length of stay in lb 66 days | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED First ALVA Middle BROWN Last OSLIN | | | 4. DATE OF DEATH Month July Day 21 Year 58 |
| 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 5-5-1894 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Globe Automatic | | 10b. KIND OF BUSINESS OR INDUSTRY Springing co. | 11. BIRTHPLACE (City and state or country) Wilmra, ARK. 1 |
| 13a. FATHER'S NAME Cosby Oslin | | 13b. MOTHER'S MAIDEN NAME Emmer Brown | 14. NAME OF HUSBAND OR WIFE AIGIE Mays Oslin |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W. W. I. | | 16. SOCIAL SECURITY NO. 380-03-4961 | 17. INFORMANT University of Mo. Medical Records Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE GRANULOCYTIC (502-822) LEUKEMIA DUE TO (b) UNKNOWN DUE TO (c) — with Hemothorax (370-400.7) 2043F (810-911). | | | INTERVAL BETWEEN ONSET AND DEATH MONTHS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) TRAUMA TO THORACIC CAGE (5/14/58) 20 MYXEDEMA | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input checked="" 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.) 3. DEPRESSIVE REACTION (000-x06) | |
| 20c. TIME OF INJURY Hour 5 p.m. Month, Day, Year 5 14 58 | | 20b. PT. stepped off scaffolding of building and fell a pp. 12 feet to ground | |
| 20d. INJURY OCCURRED WHILE AT <input checked="" 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.) new construction | |
| | | 20f. CITY, TOWN, OR LOCATION SHELBYNA COUNTY SHELBY STATE MO | |
| 21. I attended the deceased from 7 JUNE, 1958 to 20 July, 1958 and last saw her alive on 20 July, 1958 Death occurred at 5:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Thomas W. Burns, M.D. (Degree or title) | | 22b. ADDRESS UNIV. of MISSOURI MEDICAL CENTER, COLUMBIA | |
| | | 22c. DATE SIGNED 7/21/58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE July 21, 1958 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) Shelbina Missouri | |
| 24. FUNERAL DIRECTOR Mayer Funeral Home - Shelbina, Mo. | | 25. DATE RECD. BY LOCAL REG. July 21 1958 | |
| | | 26. REGISTRAR'S SIGNATURE Mrs R E Palmer | |

(Licensed Embalmer's Statement on Reverse Side)

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.....

Jack H. Hayes

Licensed Embalmer No. *3699*

P. O. Address *Shelburne, Vt*

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.