

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-017691

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **2453**

STATE FILE NUMBER

AMENDED **FILED JUN 5 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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) Kansas City		Length of stay in Ib 15 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A. Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3119 Brooklyn		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Pervis Middle J. Last Osborn				4. DATE OF DEATH Month May Day 13 Year 1961									
5. SEX male		6. COLOR OR RACE negro		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-5-1925		9. AGE (last birthday) 35		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Postal Worker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Quitna, La.			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME Jim Osborn				13b. MOTHER'S MAIDEN NAME Florence Estill				14. NAME OF HUSBAND OR WIFE Willa M.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W. W. II				16. SOCIAL SECURITY NO.		17. INFORMANT Willa M. Osborn 3119 Brooklyn Official Records V. A. Hosp.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease												INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 a.m. p.m.		Month, Day, Year											
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. VA Hosp attended the deceased from April 10 1961 to May 13, 1961 and last saw her/him alive on _____ Death occurred at 2:00P. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) T.J. Fritzlen M.D.						22b. ADDRESS VA. Hospital K. C. Mo.				22c. DATE SIGNED 5-14-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5-20-61		23c. NAME OF CEMETERY OR CREMATORY Lincoln		23d. LOCATION (City, town, or county) Kansas City, Mo.		(State)					
24. FUNERAL DIRECTOR Mrs. Meeks Mortuary K. C. Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 5-18-61		26. REGISTRAR'S SIGNATURE Ruth Long					

1961 9 NNR

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 Millard B. [Signature]

Licensed Embalmer No. 5013

P. O. Address F. C. [Signature]

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.