

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3204-62-023327

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JUL 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>64 Years</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED IN HOSPITAL OR INSTITUTION <b>3400 CAMPBELL STREET BRA-TON NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6519 Woodland Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>Robert</b> Last <b>OSTROM</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/78</b>
9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>HICKORY COUNTY, MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. FATHER'S NAME <b>CHARLES OSTROM</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Hernquist</b>		14. NAME OF HUSBAND OR WIFE <b>Ellen Ostrom</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Carl H. Ostrom, 6519 Woodland Av.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous Primary Prostate.</b> 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) <b>Arteriosclerosis.</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs (?)</b>		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 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 _____ 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. I attended the deceased from <b>Oct 1944</b> to <b>6/15/62</b> and last saw <sup>her</sup> him alive on <b>6/14/62 11 P.M.</b> Death occurred at <b>1:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Edmund C. Casper, M.D.</b>		22b. ADDRESS <b>315 Nichols Rd. MC, No</b>	22c. DATE SIGNED <b>6/15/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/18/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery Kansas City, Missouri</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth N Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

Mr Edwin George Cassin  
242 Playa Medical Bldg - 315 Market Road  
2:00-5:00

**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 Dean W Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Mo.

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.