

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 13 1939

791  
1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Childrens Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Sandra Berniece Osborn 216

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, child

6. (b) Name of husband or wife child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 10 - 25 - 38  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 11 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Columbus Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business child

MOTHER FATHER { 12. Name Walter Osborn  
13. Birthplace Columbus Kansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Hazel Choate  
15. Birthplace Okla. home  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Spedder

(b) Address 416 S. Kings highway

17. (a) removal (b) Date thereof 10-8-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus, Kansas

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.

19. (a) OCT 6 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County \_\_\_\_\_  
(c) City or town Columbus (If outside city or town limits, write "RURAL") NR  
(d) Street No. 400 N. Indiana (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6  
year 39 hour 2:30 minute \_\_\_\_\_ a. M.

21. I hereby certify that I attended the deceased from 10-1-39  
\_\_\_\_\_ 19\_\_\_\_, to 10-6- 1939;

that I last saw her alive on 10-5-39, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death bilateral orbital  
tumors with acute leukemia  
non malignant

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Bilateral orbital tumors

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. J. Bleth (M. D. or other) \_\_\_\_\_

Address 501 N. Kings Highway Date signed \_\_\_\_\_

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

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 this body is not embalmed, above space should be left blank.**