

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

38694

DEC 11 1939  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4458

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Gen'l Hosp. No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hrs.  
In this community About 4 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1604 Paseo  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Mr. Edward Osborne  
3. (b) If veteran, name war No  
3. (c) Social Security No. 487-07-5860

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 Day 18 1939  
year \_\_\_\_\_ hour 9:20 P M.

4. Sex Male 5. Color or race Colored  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Phyllis Osborne  
6. (c) Age of husband or wife if alive 29 years  
7. Birth date of deceased Oct. 13 1909  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I have \_\_\_\_\_ lives on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
34 0 5 hr. \_\_\_\_\_ min.

Immediate cause of death Uremia

9. Birthplace Kingfisher Co. Okla.  
(City, town, or county) (State or foreign country)

Due to Glycosuria, albumin & acid  
Psychonephrosis

10. Usual occupation Laborer

Due to Unethical Street use  
Other conditions can undetermined  
(Include pregnancy within 3 months of death)

11. Industry or business 809 McRee Garage

Major findings: \_\_\_\_\_

12. Name Joe Osborne

Of operations \_\_\_\_\_

18. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name Barbara Walker

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

15. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

(b) Date of occurrence \_\_\_\_\_

16. (a) Informant's own signature Phyllis Osborne  
(b) Address 1604 Paseo 2nd Floor

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

17. (a) Removal (b) Date thereof 11 22 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(c) Place: burial or cremation Hennessy, Okla.  
18. (a) Signature of funeral director Adkins Bros.  
(b) Address Kansas City Mo.

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

19. (a) Nov 22 1939 (b) M. M. Osborne  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ 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 Arvey Andrews

Licensed Embalmer No. 3974

P. O. Address 1607 N 10 St KCR

**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.**