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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5006

FILED MAR 10 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 881

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:
401 No. VAN BRUNT
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 38 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County JACKSON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 401 N. VAN BRUNT.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FANNIE ELLIS OSBORNE

3. (b) If veteran, name war NO

3. (c) Social Security No. NO ONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JOHN F. OSBORNE

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JUNE 20 1868
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 24 1947
year 1947 hour 7 minutes 38 P. M.

21. I hereby certify that I attended the deceased from FEB. 21 1947 to FEB. 24 1947
that I last saw her alive on FEB. 24 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>4</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage
3 days

Due to arteriosclerosis

Due to _____

9. Birthplace MONROE CO. MISSOURI
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations § 30

Of autopsy _____

10. Usual occupation AT HOME

11. Industry or business HOUSEWIFE

MOTHER FATHER

12. Name ROBERT COTTINGHAM

13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

14. Maiden name SARAH DUVAL

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

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? _____

16. (a) Informant Miss Frances Osborne

(b) Address 401 Van Brunt Blvd

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof FEB. 27, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY

(Specify type of place) _____

(e) Means of injury 0

23. Signature J. J. Farnsworth (M. D. or other) _____

Address 1103 Grand Date signed 2/26/47

18. (a) Signature of funeral director D. J. Thompson

(b) Address 1401 Brush Creek Blvd

19. (a) 2-26-47 (Date received local registrar)

(b) Shiraldine Holmes (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

Remu

l. m. j. j. j.

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 *Paul Rapp*
Licensed Embalmer No. *23458*
P. O. Address *K. S. Ma.*

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, fact should be so stated above.