

JAN 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1428**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **9**

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, write RURAL and give town or township) Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 55 yrs.		STREET ADDRESS (If rural, give location) 3 East 55th Terrace	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) MILDRED	b. (Middle) W.	c. (Last) OSTERSTROM	4. DATE OF DEATH (Month) (Day) (Year) Jan. 1, 1956
-------------------------------------	---------------------------	-----------------------	-----------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 10, 1900	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	--	--

13a. FATHER'S NAME Jacob G. Wine	13b. MOTHER'S MAIDEN NAME Ida Sawyer	14. NAME OF HUSBAND OR WIFE Carl G. Osterstrom
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 487-36-3655	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carl G. Osterstrom, 3 E. 55th Terrace,
--	--	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amiotrophic Lateral Sclerosis		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			3561

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **Sept 1953** to **Jan 1**, 19**56**, that I last saw the deceased alive on **Dec 31st**, 19**55**, and that death occurred at **12:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. C. Weiford (Degree or title) M.D.	23b. ADDRESS 330 West 47th St. K.C. Mo.	23c. DATE SIGNED Jan 2nd 1956
---	---	---

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE Jan. 3, 1956	24c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
--	-------------------------------	---	---

DATE REC'D BY LOCAL REG. 1-3-56	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary, Kansas City, Mo.
--	--	--

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

WE: 1-1-4728
HOME - 5514 Norwood
SK: 1-1514

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 *Clayton F. Barnes*

Licensed Embalmer No. 479

P. O. Address *K. E. M.*

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.