

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-62-023324**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3341

**FILED JUL 16 1962**

VS 300  
Rev. 4/59

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204.3

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1260

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF **W. A. Slentz, Medical Certification**

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

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> 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>56 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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LUKE'S HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5314 WAYNES AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>OLLIE LEORA OSBORN</b>			4. DATE OF DEATH Month Day Year <b>JUNE 24 1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	9. AGE (last birthday) <b>74</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <b>EUREKA, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>FREDERICK FOSTER</b>		13b. MOTHER'S MAIDEN NAME <b>EFFIE LYON</b>	14. NAME OF HUSBAND OR WIFE <b>WILLIAM B. OSBORN</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>WILLIAM B. OSBORN</b> Address <b>5314 WAYNES AVENUE</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>Acute myelogenous leukemia.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 months.</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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>March 20, 1953</b> to <b>June 24, 1962</b> and last saw him/her alive on <b>June 24, 1962</b> Death occurred at <b>12:45 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. A. Slentz, M.D.</b>		22b. ADDRESS <b>4320 Wornall Road, K. C., Mo.</b>	22c. DATE SIGNED <b>6/25/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JUNE 27, '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HIGHLAND PARK CEMETERY KANSAS CITY KANSAS</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>6-25-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth H. Long</b>

W. William Addison Hunt  
420 Plaza Parkway Bldg # 4120 of e mobile Parkway  
3rd

**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 W. William Addison Hunt

Licensed Embalmer No. 4096

P. O. Address W. E. Hunt

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.