

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

43302*

1. PLACE OF DEATH

County Worth Registration District No. 905
Township Allen Primary Registration District No. 6216
City Denver (No. _____) (St. _____ Ward _____)

File No. _____
Registered No. _____

2. FULL NAME

David L. Osborne

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 11 / 1860</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>69</u>	<u>6</u>	<u>7</u>	<u>11</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Bata Co. Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

W. Donald Osborne

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Id.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Rena Osborne

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

14. INFORMANT

J. M. Osborne R2A
(Address) Denver, Mo.

15.

Jan 4 1930 Mrs. Maye Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 16 1929
17. I HEREBY CERTIFY, That I attended deceased from Oct 1929, to Dec 16, 1929, that I last saw him alive on Dec 20, 1929, and that death occurred, on the date stated above, at 2-A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

GRA general paralysis
BRD due to cerebral hemorrhage
162

CONTRIBUTORY (SECONDARY)

Smelly (duration) yrs. mos. 30 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. O. Hippa, M. D.

Dec. 1929 (Address) Grant City, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Rest-Cemetery Dec. 16 1929
20. UNDERTAKER Bram Boy ADDRESS Denver

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

113
114
115

