

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MAR 31 1933

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

Do not use this space.

1. PLACE OF DEATH

County Worth
Township Witchhall
City Grant City (No. _____) St. _____ Ward _____

Registration District No. 903
Primary Registration District No. 4545

File No. 8332
Registered No. 3

2. FULL NAME Samuel Washington Osborn

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Almeda Osborn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 23, 1840.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
92 2 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work General Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) fur buyer
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) my Pleasant
(STATE OR COUNTRY) Louisia

10. NAME OF FATHER M. Donald Osborn

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Grant
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Almeda Wells

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Grant
(STATE OR COUNTRY) Missouri

14. INFORMANT Sam Osborn Jr.
(Address) Grant City, Mo.

15. FILED Feb 19 1933 John Auerer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 10 - 1933

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1933, to Feb 10, 1933
that I last saw him alive on Feb 10, 1933, and that death occurred, on the date stated above, at 5:30 P. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
11B Influenza
11B Sinusitis
(duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. K. Phipps, M. D.

2-10, 1933 (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 Grant city, cemetery DATE OF BURIAL 2/12 1933

20. UNDERTAKER Arch C. Dampfle ADDRESS Grant city

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.

