

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

Do not use this space.

32455

**1. PLACE OF DEATH**

County Shannon Registration District No. 637  
Township 51 Primary Registration District No. 6084  
City (No. ....) St. .... Ward)

File No. H  
Registered No. ....

**2. FULL NAME**

Osa Ferris

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Female **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** widowed  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF** John C Ferris  
**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Apr 29 1868  
**7. AGE** Yrs. 57 MONTHS 11 DAYS 15 If LESS than 1 day, ... hrs. or ... min.

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

**9. BIRTHPLACE** (CITY OR TOWN) Renolds mo  
(STATE OR COUNTRY)

**10. NAME OF FATHER** Mr. Butkin

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) Ky  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER** Elizabeth Madison

**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) Ky  
(STATE OR COUNTRY)

**14. INFORMANT** Frank Wells  
(Address) Rector mo

**15. FILED** Oct 1 1928 Mrs. Helen Worley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) Sept 14 1928  
**17. I HEREBY CERTIFY**, That I attended deceased from Sept 11 1928 to Sept 13 1928, that I last saw him alive on Sept 13 1928, and that death occurred, on the date stated above, at 11 A. M.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**  
Diabetes Mellitus  
Diabetes Myocarditis  
CONTRIBUTORY (SECONDARY) Diabetes Myocarditis  
(duration) 5 yrs. 11 mos. 11 da.  
(duration) 4 yrs. 11 mos. 11 da.

**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?** urinalysis - etc  
(Signed) Blond H. Grant M. D.  
(Address) Salem, 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** Cedar Grove Cem **DATE OF BURIAL** 9/16 1928

**20. UNDERTAKER** H. A. Hoban **ADDRESS** Salem mo

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.

1928

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