

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

Do not use this space.

9789

1. PLACE OF DEATH

County Callaway  
Township Fulton No  
City State Hosp

Registration District No. 104  
Primary Registration District No. 3008

File No. ....  
Registered No. 62  
St. .... (Ward) .....

2. FULL NAME

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

State Hospital No 1  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DK

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
abd 47 — —

8. OCCUPATION OF DECEASED

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) DK

(STATE OR COUNTRY) .....

10. NAME OF FATHER DK

11. BIRTHPLACE OF FATHER (CITY OR TOWN) DK

(STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER DK

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) DK

(STATE OR COUNTRY) .....

14. INFORMANT (Address) Reeds Hospital No 1 Fulton Mo

15. FILE NO. 5 1929 R. N. Creas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to March 6, 1929

that I last saw h. alive on March 7, 1929, and that death occurred, on the date stated above, at State Hospital No 1

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Tuberculosis Lungs

CONTRIBUTORY (SECONDARY) DK (duration) 1 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED DK

IF NOT AT PLACE OF DEATH, .....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF .....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Stengel Laboratory

(Signed) R. N. Creas M. D.

, 19 March 7 State Hospital No 1

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Waukegan City Cemetery DATE OF BURIAL 3/6 1929

20. UNDER TAKER Crestopkin Waukegan Mo ADDRESS .....

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.

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23  
1929

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PARENTS

