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

Do not use this space.

39899

1. PLACE OF DEATH
County Callaway — Registration District No. 104 — File No.
Township — Primary Registration District No. 3008 — Registered No. 272
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME Mary Chorn (Chorn)
(a) Residence. No. Fayette Mo St., ... Ward. State Hospital Mo
(Usual place of abode) (If nonresident give city or town and State) Mo
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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: married

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

7. AGE: Stated 65 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): DK

PARENTS
10. NAME OF FATHER: DK
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): DK
12. MAIDEN NAME OF MOTHER: DK
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): DK

14. INFORMANT (Address): Records State Hospital No. Fulton Mo

15. Dec 28 1929 R. McCrews, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 27/1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1929, to Dec 27, 1929 that I last saw h... alive on Dec 26, 1929 and that death occurred, on the date stated above, at 5:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Acute Hypostasis

130 / 1327 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Unknown

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [signature], M. D
, 19 (Address) 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, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Fayette Mo — DATE OF BURIAL: Dec 30 1929

20. UNDERTAKER: G. T. Halley, Fayette 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.

NOV 30 1929

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31