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

Do not use this space.

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1. PLACE OF DEATH

County: Callaway Co — Registration District No. 104 — File No.

Township: Fulton — Primary Registration District No. 3008 — Registered No. 15

City: Fulton Mo (No. ..... St. ..... Ward)

2. FULL NAME My Hill Dorin

(a) Residence. No. Scotland Co Mo St., ... Ward. State Hospital No 1 (If nonresident give city or town and State)

(Usual place of abode)

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: Abt 61 — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeping
(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): D K

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

14. INFORMANT: Reeves Hospital No (Address) Fulton Mo

15. Filed: June 22 1930 R. N. Crews, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1929, to Jan 20, 1930, that I last saw him alive on Jan 20th, 1930, and that death occurred, on the date stated above, at 10 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
My Cerebritis (Chronic)
92 C
66 B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Gorin
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) D H Higgins, 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. Fulton Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Gorin, Mo, — DATE OF BURIAL: D, K, 19

20. UNDERTAKER: Herndon-Taylor Furn-Co, — ADDRESS: Fulton, 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.

FEB 18 1930

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