NOV 21 1930

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

Do not use this space.

32242

1. PLACE OF DEATH
County Callaway
Township ~~Fulton~~
City Fulton (No. ..... St. ..... Ward)
Registration District No. 104
Primary Registration District No. 3008
File No. .....
Registered No. 222

2. FULL NAME Meyer Eisburg
(a) Residence. No. State Hosp #1, Fulton, Mo. Ward. Kansas City, Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 12 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	53	—	—	

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER No Information
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER No Information
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Record of State Hosp #1
(Address) Fulton, Mo.

15. FILED 10 15, 1930 R. N. Creus
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 5, 1930

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to Oct 5, 1930 that I last saw him alive on Oct. 5, 1930, and that death occurred, on the date stated above, at 4:10 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Manic Depressive Psychosis
(Acute Mania)
89
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 77
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? None
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) C. C. Abelt, M. D.
, 19 (Address) Fulton, 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	DATE OF BURIAL
Kansas City Mo	O K 19
20. UNDERTAKER	ADDRESS
Herndon Taylor	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.