

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.

JUN 20 1934

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

Do not use this space.

**1. PLACE OF DEATH**

County Calloway Registration District No. 104  
 Township Fulton Primary Registration District No. 3008  
 City Fulton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 15950  
 Registered No. 111

**2. FULL NAME**

(a) Residence, No. Edna, Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 19 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

<p><b>3. SEX</b> <u>Male</u></p>	<p><b>4. COLOR OR RACE</b> <u>White</u></p>	<p><b>5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)</b> <u>d.k.</u></p>		
<p><b>5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF</b></p>				
<p><b>6. DATE OF BIRTH (MONTH, DAY, AND YEAR)</b> <u>d.k.</u></p>				
<b>7. AGE</b>	<b>YEARS</b>	<b>MONTHS</b>	<b>DAYS</b>	<b>IF LESS than 1 day, _____ hrs. or _____ min.</b>
<u>about 72</u>	<u>d.k.</u>	<u>d.k.</u>	<u>d.k.</u>	<u>d.k.</u>
<b>OCCUPATION</b>	<p><b>8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.</b> <u>d.k.</u></p>			
	<p><b>9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.</b></p>			
	<p><b>10. Date deceased last worked at this occupation (month and year)</b></p>		<p><b>11. Total time (years) spent in this occupation</b></p>	
<p><b>12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)</b> <u>d.k. Mo.</u></p>				
<b>FATHER</b>	<p><b>13. NAME</b> <u>d.k.</u></p>			
	<p><b>14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)</b> <u>d.k.</u></p>			
<b>MOTHER</b>	<p><b>15. MAIDEN NAME</b> <u>d.k.</u></p>			
	<p><b>16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)</b> <u>d.k.</u></p>			
<p><b>17. INFORMANT</b> <u>Records State Hospital #1</u> (ADDRESS) <u>Fulton, Mo.</u></p>				
<p><b>18. BURIAL, CREMATION, OR REMOVAL</b> PLACE <u>Edna, Mo. Cem. May 23, 1934</u> DATE</p>				
<p><b>19. UNDERTAKER</b> <u>Edna, Mo.</u> (ADDRESS) <u>Edna, Mo.</u></p>				
<p><b>20. FILED</b> <u>May 22, 1934</u> <u>R. N. Creed</u> Registrar</p>				

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** 5-22, 1934

**22. I HEREBY CERTIFY, That I attended deceased from** Dec 1, 1933 to 5-21, 1934

I last saw him alive on 5-21, 1934 Death is said to have occurred on the date stated above, at 2 A. m.

The principal cause of death and related causes of importance were as follows:

Epilepsy

85

Myocarditis

**Other contributory causes of importance:**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No.

**23. If death was due to external causes (violence), fill in also the following:**  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

**24. Was disease or injury in any way related to occupation of deceased?**  
 If so, specify \_\_\_\_\_  
 (Signed) Josye K. Balg M. D.  
 (Address) State Hospital #1  
Fulton, Mo.

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