

MAR 16 1937

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

Do not use this space.

1. PLACE OF DEATH

County Cochran
Township St Joseph Mo
City St Joseph Mo

Registration District No. 88
Primary Registration District No. 10
State Hosp #2

File No. 5040
Registered No. 123

2. FULL NAME

(a) Residence, No. 2801 Jefferson Ave St. F.C. Ward. (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm E Gray

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 23 1892

7. AGE YEARS 44 MONTHS 9 DAYS 8 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as splinter, sawyer, bookkeeper, etc. Practise Nurse

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cameron Mo

13. NAME Mrs Anna

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Douglas

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) State Hosp Records

18. BURIAL, CREMATION, OR REMOVAL PLACE near Colo, Mo DATE 2/3 1937

19. UNDERTAKER (ADDRESS) Chapman & Archer Co. Liberty Mo

20. FILED Feb 3 1937 A J Matthews Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1 1937

22. I HEREBY CERTIFY, That I attended deceased from Feb 25 1937 to Feb 1 1937

I last saw him alive on Jan 31 1937 Death is said to have occurred on the date stated above, at 1 A m.

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

Paritic Seizures
g 27

Other contributory causes of importance:
Syphilitic Central Nervous System - Arterio Sclerotic Paralysis

Name of operation None Date of.....
What test confirmed diagnosis? None Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no 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 None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify.....

(Signed) George W. Forman M. D.
(Address) State Hosp #2 St Joseph Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 1 X7294

