FEB 20 1928 53

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

Do not use this space.

210

1. PLACE OF DEATH
County: Buchanan — Registration District No.: 85 — File No.:
Township: Washington — Primary Registration District No.: 1001 — Registered No.: 17
City: St Joseph (No. State Hospital #2 St. ..... Ward)

2. FULL NAME: Francis A S Rebo
(a) Residence. No. State Hospital #2 St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): about 1852 unknown

7. AGE: 76 YEARS — MONTHS: unknown — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teacher
(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): Mo

PARENTS
10. NAME OF FATHER: Burnard M Rebo
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Unknown Fields
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: State Hosp x 2
(Address): St Joseph Mo

15. FILED JAN 7, 1928 — John G. Wh — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1/6/28 19

17. I HEREBY CERTIFY, That I attended deceased from 7/15/25, 19.., to 1/6/28, 19.., that I last saw h..... alive on 1/6/28, 19.., and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia
162
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) J A Romeiser, M.D
1/6, 1928 (Address) State Hospital x 2

*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: Alexandria Mo — DATE OF BURIAL: Jan 7th 1928

20. UNDERTAKER: E. R. Sidenfaden — ADDRESS: 602 So. 10

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.