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

Do not use this space. 373

1. PLACE OF DEATH
County: Callaway
Registration District No.: 104
Primary Registration District No.: 3008
File No.:
Registered No.: 15
Township:
City: Fulton (No. ..., ... St. ..... Ward)

2. FULL NAME: Herman Schafer State Hospital
(a) Residence. No. Chamois 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: 7 yrs. 1 mos. 20 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
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): No information

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ...hrs. or ....min.
49	No information		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Feebleminded
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Bryan Mo.

PARENTS

10. NAME OF FATHER: No information
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) No information
12. MAIDEN NAME OF MOTHER: No information
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) No information

14. INFORMANT: State Hospital records
(Address) Fulton Mo

15. Jan 31, 1928 T. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jany. 28 - 1928

17.
I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on Jany. 27 -, 1928, and that death occurred, on the date stated above, at 5:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Died suddenly setting up in chair - Death supposed to be due to apoplexy.
72 A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) None
(duration) ..... 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?
(Signed) T. P. Frazer, M. D
1-28-, 1928 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Morrison Mo
DATE OF BURIAL: O.K. 19

20. UNDERTAKER: Herndon Taylor
ADDRESS: Fulton Mo.

NB. 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.