MAR 21 1928

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

Do not use this space.

6127

1. PLACE OF DEATH
County St. Francois
Township St. Francois
City ~~Near Farmington~~ (No. ..... St. ..... Ward)
Registration District No. 773
Primary Registration District No. 6018A
File No. .....
Registered No. 27

2. FULL NAME Laura May Stone
(a) Residence. No. State Hospital No. 4 St., ... Ward. Fredericktown, Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. 10 mos. 23 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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) Not known

7. AGE: Years 50; Months ?; Days ?; If LESS than 1 day, ... hrs. or ..... min.

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) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Not known
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

14. INFORMANT Commitment Papers Hosp No 4
(Address) Farmington Mo

15. FILED 2-23 1928 B J Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-21- 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Feb-21-, 1928 that I last saw h... alive on Feb 21, 1928, and that death occurred, on the date stated above, at 7 40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage, apoplexy, 82A

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(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) Chas R Burns, M. D
, 19 (Address) State Hospital No. 4.

*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: Hospital Cemetery
DATE OF BURIAL: 2-23-28

20. UNDERTAKER: Chet. Doubet for Hosp No 4
ADDRESS: Farmington

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.