

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

Do not use this space.

8065

1. PLACE OF DEATH

County Callaway Co
Township Fulton
City Fulton

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 52
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. State Hospital No 1 St. Lansing Mo Ward _____
(Usual place of abode) Fulton
Length of residence in city or town where death occurred _____ yrs. _____ mos. da. How long in U.S., if of foreign birth? 2 yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
Att 67 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse Keeper
(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) _____

PARENTS

10. NAME OF FATHER D. G.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER N. K.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14.

INFORMANT Charles Hospital No 1
(Address) Fulton Mo

15.

FILED 3-23-28 R. N. Crees
REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 27 1928

17. I HEREBY CERTIFY, That I attended deceased from March 27 1928, to March 28 1928, that I last saw her alive on March 27 1928, and that death occurred, on the date stated above, at 4:30 p.m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Subealous Lungs
2/23A
3/15/28
Senile Psychosis (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Senile Psychosis (duration) 3 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH... N.G.

DID AN OPERATION PRECEDE DEATH... no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Microscopic Laboratory
(Signed) Dr. J. H. Young, M. D.
, 19 March Hospital No 1

*State the DISEASE CAUSING DEATH, or in death from injury, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lansing Mo DATE OF BURIAL 3/25 1928

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo

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.

