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

Do not use this space.

10353

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. 46

2. FULL NAME: Deal Delona

(a) Residence. No. State Hospital No. 4 St., ... Ward. Irondale, Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 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): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: George Delona

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Not known

7. AGE: Years 67 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Rolla
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER: Cynthia McCalister

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Nashville
(STATE OR COUNTRY): Tennessee

14. INFORMANT: Hospital Records
(Address): Farmington, Mo.

15. FILED 3-31-1928 B. J. Robinson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 29 1928

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1928, to March 29, 1928, that I last saw h. alive on March 28, 1928, and that death occurred, on the date stated above, at 1:50 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of the Insane

(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? Lab.
(Signed) [illegible], 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: 3-29-28 19

20. UNDERTAKER: Hospital No 4. C. Talbot
ADDRESS: Farmington 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St. Francois — Registration District No. 773 — File No.
Township — Primary Registration District No. 6018a — Registered No. 46
City (No. St. Ward)

2. FULL NAME Deal Delona
(a) Residence. No. St., 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) W

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 5-22-28, 19 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of the insane
Syphilis
(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? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

[redacted] DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) [redacted] NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HO[redacted]

19. [redacted] BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. [redacted] ER — ADDRESS

SUPPLEMENTARY

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N. B. [illegible] of information sh[illegible] AGE should be stated EXACTLY. PHYSICIANS should state CAU[illegible] DEATH in plain terms, [illegible] properly classified. Exact statement of OCCUPATION is very important.
REG[illegible] SHALL NOT RECEIVE [illegible] ATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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