JUN 4 1928

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

Do not use this space.

14563

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. 64

2. FULL NAME Malinda Mauser
(a) Residence. No. Hornersville, 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 yrs. mos. 14 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) married

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

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

7. AGE 30 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) Dunklin Co Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER J. B. Burton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ind.
12. MAIDEN NAME OF MOTHER Ellen Robinson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.
(STATE OR COUNTRY)

14. INFORMANT Hospital Records
(Address) Farmington Mo

15. FILED 4-24, 1928 B. J. Robinson
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1928, to April 21, 1925 that I last saw her alive on April 21, 1925, and that death occurred, on the date stated above, at 2:20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

31

(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) Chas R Burns, M. D
4-23, 1928 (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 4-23-28 19

20. UNDERTAKER Hospital No 4
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.