

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

16210

1. PLACE OF DEATH

County Buchanan
Township North Buchanan
City Joseph (No. State Hospital #2)

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 600
St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. _____ 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. 3 mos. 8 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella Colby about _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 Unknown

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) Boston
(STATE OR COUNTRY) Massachusetts

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) State Hospital #2
State Hospital #2

15. FILED 1, 1928 REGISTRAR J. M. G. G.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1928

17. I HEREBY CERTIFY That I attended deceased from Apr. 1, 1928, to May 8, 1928 that I last saw her alive on May 8, 1928, and that death occurred, on the date stated above, at 7:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia
164 Unknown
(duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Expansion due to senility (duration) yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Fluorcal
(Signed) J. D. Guster M. D.

May 8, 1928 (Address) State Hospital #2, Joseph

*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 Ashtary Cemetery DATE OF BURIAL May 12, 1928

20. UNDERTAKER E. R. Biderfaden ADDRESS 602 So 10th

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.

