

27 1928

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

Do not use this space.

28308

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Near Farmington

Registration District No. 773
Primary Registration District No. 6018A

File No. _____
Registered No. 123
St. _____ Ward _____

2. FULL NAME

Hobart Stuart
State Hospital No. 4
Webster Groves, Mo

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 3 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) Separated

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not known

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
33 ? ?

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

9. BIRTHPLACE (CITY OR TOWN) Oconto
(STATE OR COUNTRY) Wisconsin

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Commitment Papers
(Address) _____

15. FILED 8-25-28 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 1928

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1928, to Aug 23, 1928 that I last saw em alive on Aug 23, 1928, and that death occurred, on the date stated above, at 11:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis or
Paras

83
82 D (duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) MO (duration) yrs. _____ mos. _____ ds.

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical & Lab.
(Signed) P. S. Tate, M. D.

8-24, 1928 (Address) Hosp. #4 Farmington Mo

*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 Post View Cemetery
Hospital Cemetery DATE OF BURIAL 8-26-1928

20. UNDERTAKER Farmington Und. Co. ADDRESS Farmington Missouri

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.

DEPARTMENT RECORD

