

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

Do not use this space.

32903

1. PLACE OF DEATH

County Callaway Registration District No. 104
 Township _____ Primary Registration District No. 3008
 City Fulton (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 193

2. FULL NAME

(a) Residence. No. Rose Brown St. _____ Ward _____
 (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.

State Hospital Fulton Mo
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
Age 69

8. OCCUPATION OF DECEASED

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

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 State Hospital Nat (Address) Fulton Mo

15. OK 20-28 REGISTRAR R. N. Crew

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 20 1928

17. I HEREBY CERTIFY, That I attended deceased from my _____ 1928, to Oct 20, 1928 that I last saw h. _____ alive on Oct 19, 1928, and that death occurred, on the date stated above, at Fulton, Mo.

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

83
10 Syphilis
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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

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

20. WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Chemical Pathology
 (Signed) Dr. J. H. ... M.D.,
 , 19 _____ (Address) State Hospital Nat

*State the DISEASE CAUSING DEATH, or if death the result of VIOLENCE, CAUSE, STATE (1) MEANS AND NATURE OF INJURY, and, if death the result of SUICIDE, or HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kansas City Mo DATE OF BURIAL Oct 21 1928

20. UNDERTAKER Ch. Bell 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. 1928

