

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

Do not use this space.

5677

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.

MAR 21 1929  
 14  
 3  
 7

**1. PLACE OF DEATH**

County Walloway Co Registration District No. 104  
 Township Fulton Primary Registration District No. 3008  
 City Fulton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 30

**2. FULL NAME**

(a) Residence. No. Home Myer St. \_\_\_\_\_ Ward State Hospital  
 (Usual place of Abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. — mos. — da. How long in U.S., if of foreign birth? / yrs. — mos. — da.

**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 Home

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 M.C.  
 (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 M.K.

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

12. MAIDEN NAME OF MOTHER M.K.

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

14. INFORMANT Home Hospital (Address) Fulton

15. FILE NO. 2-5-99 REGISTRAR R. W. Crews

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 19 29

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 19 21, to Feb 3, 19 29  
 that I last saw h.i. alive on Feb 3, 19 29, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Myocarditis  
920  
907 (duration) yrs. 3 mos. da.

CONTRIBUTORY (SECONDARY) Arteriosclerosis  
 (duration) 7 yrs. — mos. — da.

18. WHERE WAS DISEASE CONTRACTED DK  
 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) D. H. Young, M. D.  
 , 19 (Address) State Hospital

\*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 State Hospital Grounds DATE OF BURIAL 2/27 19 29

20. UNDERTAKER J. J. Tibbs ADDRESS Fulton Mo.

