

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

Do not use this space.

1. PLACE OF DEATH

County Callaway Registration District No. 104

Township Fulton Primary Registration District No. 3008

City Fulton (No. estate Hoop) St. _____ Ward _____

File No. 9799
Registered No. 63
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Miss Matelda Brooks 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. 7 mos. 22 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

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

No information

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. _____ min.

69

No other information

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Mo. Callaway Co Mo.

10. NAME OF FATHER

No information

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

No information

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

State Hospital Records
Fulton Mo

15. DATE

REGISTERED

Mar 5 1929 R. M. Coors REGISTRAR

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

March 5 - 1929

17.

I HEREBY CERTIFY That I attended deceased from March 4 - 1929, to March 5 - 1929, and that I last saw her alive on March 5 - 1929, and that death occurred, on the date stated above, at 11:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Degeneration
tripped toe on the floor and fell
fracturing hip

CONTRIBUTORY (SECONDARY)

Deceubites for 6 mos from
result of a fractured hip used
open air habit

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH?

No DATE OF _____

20. WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Dr. R. H. Coors M. D.

3/5 1929 (Address) Fulton 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

DATE OF BURIAL

Hillcrest Cemetery

3/7 1929

20. UNDERTAKER

ADDRESS

Herndon Taylor

Fulton MO.

should be carefully applied. Each statement of OCCUPANT should be
PHYSICIAN should be

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Callaway Registration District No. 104 File No.
Township Primary Registration District No. 3008 Registered No. 63
City Fulton (No.) St. Ward)

2. FULL NAME

Mrs Matilda Brooks
(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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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
(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
(Address)

15. FILED May 29 1929 R. A. Green REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 19 29

17. I HEREBY CERTIFY That I attended deceased from
....., 19..... to
that I last saw him alive on 19....., and that
death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

myocardial degeneration
dropped the top on the floor
causing fracture of hip.
(duration) yrs. mos. ds. 8
decubitus (duration) yrs. mos. ds. 8
from result of a fractured hip

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF

185
WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. A. Green, M. D.
, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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