

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

Do not use this space.

33148

1. PLACE OF DEATH

County Caloway

Registration District No. 104

Township Fullon

Primary Registration District No. 3008

City Fullon (No.)

File No.

Registered No. 213

St. Ward

2. FULL NAME

(a) Residence. No. Yon Hill's St. Kansas City S. 15 Kansas
(Usual place of abode) State Hospital no 1 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 5 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Black

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

Divorced

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

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

DK

7. AGE

YEARS 51

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Mo

(STATE OR COUNTRY)

10. NAME OF FATHER

DK

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

DK

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

DK

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

DK

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Hospital records

15.

Oct 16 1929 R. N. Creech
REGISTRAR

2 **MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1929

17.

I HEREBY CERTIFY, That I attended deceased from April 24 1929, to Oct 14 1929, and that I last saw him live on Oct 14 1929, and that death occurred, on the date stated above, at 9:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis of the insane
83
34 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Epilepsy (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

Laboratory tests
(Signed) D. Adams, M. D.
, 19 (Address) Fullon 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

Ficksville, Mo

DATE OF BURIAL

Oct. 17, 1929

20. UNDERTAKER

Eli Bell

ADDRESS

Fullon, 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.

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PARENTS

