

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

Do not use this space.

33149

**1. PLACE OF DEATH**

County Caloway  
Township Fulton  
City Fulton (No. ....)

Registration District No. 104  
Primary Registration District No. 3008

File No. ....  
Registered No. 214  
St. .... Ward)

**2. FULL NAME** Romas Alexander

(a) Residence. No. State Hospital No 1 St. .... Ward. Joplin Mo  
(Usual place of abode)  
Length of residence in city or town where death occurred 1 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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.  
19 5 - - - - -

8. OCCUPATION OF DECEASED none she was deaf + blind since birth  
(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) Joplin Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER D K  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) D K  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER D K  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) D K  
(STATE OR COUNTRY)

14. INFORMANT Hospital records  
(Address)

15. Oct 19, 29 R. M. Crews  
FILED 19. 29 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1929

17. I HEREBY CERTIFY, That I attended deceased from April 24 1929, to Oct 19 1929 that I last saw her alive on Oct 18 1929, and that death occurred, on the date stated above, at 5 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Hepatitis 3rd  
1758  
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Congenital Syphilis  
(duration) 14 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) D C Adams M. D.  
, 19 (Address) Fulton 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 Joplin Mo DATE OF BURIAL Oct. 19 1929

20. UNDERTAKER Ch. Bell ADDRESS Fulton

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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