

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

Do not use this space.

11885

MAY 23 1930

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. 82

2. FULL NAME Marie Fagg

(a) Residence. No. State Hosp #18 St. H Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70+

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) _____ (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 Hosp records (Address) Fulton

15. April 15 1930 R. N. Crews REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to April 15, 1930 that I last saw him alive on April 15, 1930 and that death occurred, on the date stated above, at 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral hemorrhage
KLR
77

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY arterio sclerosis (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

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 chem test
(Signed) W. D. ... M. D.

4-16-1930 (Address) State Hosp Fulton

*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 _____

Kirksville, Mo April 15 1930

20. UNDERTAKER Hendon Paylor 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.

