

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

Do not use this space.

11894

PLACE OF DEATH

County Callaway
Township _____
City Fulton (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 94
St. _____ Ward _____

2. FULL NAME Virginie McLester

(a) Residence No. State Hosp #1 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. 23 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

Female white widowed

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.
71 _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(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) MO

10. NAME OF FATHER Dick

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 #1
(Address) Fulton MO

15. April 28, 1930 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 27 1930

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 27, 1930 that I last saw her alive on April 27, 1930 and that death occurred, on the date stated above, at 12 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic endocarditis
34
929

(duration) yrs. mos. 23 ds.

CONTRIBUTORY syphilis
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

9. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? chronic

(Signed) A. L. ..., M. D.

4-27, 1930 (Address) State Hosp #1 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 Elmwood, Mexico, Mo DATE OF BURIAL July 29, 1930

20. UNDERTAKER H. A. Puckett & Son ADDRESS Mexico, 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.

123-1930
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