

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

Do not use this space.

38725

PLACE OF DEATH

County Callaway
Township Fulton
City Fulton (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 266
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Arthur Co. rd. St. Ward. State Hospital No. 5
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE <u>adh 26</u>	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

DK

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

DK

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14.

INFORMANT R. N. Crews State Hospital No. 5
(Address) Fulton Mo

15.

FILED Dec 19, 1930 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19, 1930
17. I HEREBY CERTIFY. That I attended deceased from July 1929 to Dec 19, 1930 that I last saw him alive on Dec 17, 1930, and that death occurred, on the date stated above, at Dec 24, 1930 3 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Phelipus
107A
85
(duration) yrs. _____ mos. _____ ds. _____

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

1000th
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH?

no DATE OF _____

WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS?

Diagnosis
(Signed) _____, M. D.

, 19 _____ (Address) State Hospital No. 5

*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. Phelipus

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mexico, Mo.

Dec 22, 1930

20. UNDERTAKER

ADDRESS

W. E. Phillips

Mexico

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.

JAN 9 1931

