

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

Do not use this space

38727

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. 268

2. FULL NAME

Thomas Paul Robert
(a) Residence. No. Greenwood Ave. St. _____ Ward. State Hospital No. 1
(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>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>DK</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE <u>alt 51</u>	YEARS —	MONTHS —
	DAYS —	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>DK</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>DK</u> (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) DK

PARENTS	10. NAME OF FATHER <u>DK</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>DK</u>
	12. MAIDEN NAME OF MOTHER <u>DK</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>DK</u>

14. INFORMANT Friends Hospital No. 1
(Address) Fulton Mo

15. Dec 24 1930 R. M. Cross
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 / 1930

17. I HEREBY CERTIFY, That I attended deceased from m. h. d. Dec 24 1930 to Dec 24 1930 that I last saw him alive on Dec 23 1930 and that death occurred, on the date stated above, at State Hospital No. 1.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

epilepsy
55
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) DK
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) DK M. D.
, 19 Dec 24 1930 (Address) State Hospital No. 1

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. DK

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Greenwood, Mo</u>	DATE OF BURIAL <u>Dec. 25 1930</u>
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20. UNDERTAKER <u>Rev G Wallace</u>	ADDRESS <u>Fulton Mo.</u>
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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 19 1931

WRITE PLAINLY, WITH OUPADING INK—THIS IS A PERMANENT RECORD

