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

Do not use this space.

PLACE OF DEATH
County: Callaway — Registration District No.: 104
Township: — Primary Registration District No.: 3004
City: Fulton (No. 4 St. Ward)

File No.: 389
Registered No.: 5

2. FULL NAME: Bertha M Euler
(a) Residence. No. 6 Gremmel 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF: Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR):
7. AGE: Years 73 Months — Days — If LESS than 1 day, ...hrs. or ...min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY): DK

PARENTS
10. NAME OF FATHER: DK
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTY): DK
12. MAIDEN NAME OF MOTHER: DK
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTY): DK

14. INFORMANT: Friends Hospital No 1
(Address): Fulton Mo
15. FILED Jan 9, 19 31 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 8, 1931
17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930, to Jan 8, 1931, that I last saw h. alive on Jan 8, 1931, and that death occurred, on the date stated above, at 7:20 AM m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
89 D
C4
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (SECONDARY): Manic Depressive Psychosis
(duration) 3 yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED: State
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) L. H. Young M. D.
, 19 (Address) State Hospital No 1

*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: Hermann City Cemetery — DATE OF BURIAL: 1/10/31
20. UNDERTAKER: E. Kuedzie — ADDRESS: Hermann Mo

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

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.