

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

28121
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township 0 Primary Registration District No. 3008 Registered No. 197
 (c) City Fulton (d) Street No. State Hospital no 1 St. 197
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. State Hospital no 1 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 DK
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DK
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 DK DK
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Deacon
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 3 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1940, to Aug 8 1940
 I last saw him alive on Aug 3 1940. Death is said to have occurred on the date stated above, at 8:00 p.m.
 The principal cause of death and related causes of importance were as follows:

General paralysis of Insane

Date of onset

Other contributory causes of importance:

Depletion of central nervous system

Name of operation Nil & Clin Date of
 What test confirmed diagnosis? Nil & Clin Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) Jornah Thomas, M. D.
 (Address) State Hospital no 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Traverse City Mich
 13. NAME Dont
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Know
 15. MAIDEN NAME Dont
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Know
 17. INFORMANT (ADDRESS) Mrs. O. Rosenbloom
H.L. Mo. 415. West 70th
 18. BURIAL, CREMATION, OR REMOVAL PLACE R.C. Mo ? DATE 8 Aug 4 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J.P. Louis Funeral
3400 Woodlawn
 20. FILED Aug 4 1940 R.N. Crews
 Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be extremely supplied. AGE should be stated EXACTLY. PHYSICIANS should state

No Security Number

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.