

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

Do not use this space.

31727

**1. PLACE OF DEATH**

County St. Francois  
Township St. Francois  
City Near Farmington (No. ....)

Registration District No. 773  
Primary Registration District No. 6018A

File No. ....  
Registered No. 131 St. .... Ward)

**2. FULL NAME**

(a) Residence No. Minnie O. Burns 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. 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 Married

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.

30 6 25  
6 15

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(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) Oceola Arkansas

10. NAME OF FATHER Mr. Gordon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Sarah Lee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

**14.**

INFORMANT Hospital Records  
(Address) Farmington, Mo.

**15.**

FILED 9-9-1929 J. Robinson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 9, 1929

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1928 to Sept. 9, 1929 that I last saw him alive on Sept. 9, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Paralysis (General paralysis of the insane)  
83 (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY? .....

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Ralph H. Harker, M. D.

9-9-1929 (Address) Farmington Mo

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Cape Girardeau Mo 9-10 1929

20. UNDERTAKER ADDRESS

Walters and Co Cape Girardeau Mo

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.

DEPARTMENT RECORD

94  
24 1929

