

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

Do not use this space.

1. PLACE OF DEATH

County St. Francois  
Towship St. Francois  
City Mar. Farmington (No. ....)

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

File No. 19212  
Registered No. 910  
St. .... Ward)

2. FULL NAME

(a) Residence No. Whim Township St. Francois Co. Ward. ....  
(Usual place of abode)

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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mollie Straughan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sep 23 1875

7. AGE YEARS 53 MONTHS 8 DAYS 23 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(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) St. Genevieve Co. Mo

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Genevieve Co. Mo.

12. MAIDEN NAME OF MOTHER ?

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

14. INFORMANT State Hosp. records (Address) Farmington Mo.

15. FILED 5-25-29 J. T. Robison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to May 25, 1929. that I last saw h. her alive on May 25, 1929, and that death occurred, on the date stated above, at 11:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemiplegic Chorea  
97B

many years yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. can't say

19. DID AN OPERATION PRECEDE DEATH. no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical (Signed) P. T. Fain, M. D.

5-25, 1929 (Address) Hosp #4 Farmington Mo

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

C. R. Boyer Dr. Logg

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.

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

50 1929

