CAUSE OF DEATH 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.

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

PLACE OF DEATH

County: Dent

Township: Franklin
or
Village:
or
City: (NO. St.: Ward)

Registration District No. 266 File No. 27884

Primary Registration District No. 5373 Registered No. 39

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Edward A. Martin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 19 (Day), 1907 (Year)

AGE: 3 yrs. 10 mos. 21 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

BIRTHPLACE (City or town, State or foreign country): Dent Co Mo

PARENTS
NAME OF FATHER: Edward A. Martin
BIRTHPLACE OF FATHER (City or town, State or foreign country): Dent Co Mo
MAIDEN NAME OF MOTHER: Virgie L. Rawlston
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Polk Co Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. F. McMurtry

(ADDRESS) Salem Mo.

Filed Aug 1 1911 J. C. Welch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 10 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from May 8, 1911, to May 9, 1911, that I last saw him alive on May 9, 1911, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) A. F. McMurtry M. D.

July 31 1911 (Address) Salem Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Union Grove yard

DATE OF BURIAL: May 11 1911

UNDERTAKER: N. D. Hobson

ADDRESS: Salem Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

MISSOURI STATE B
BUREAU OF VITA
CERTIFICATE

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered

(NO. _____, _____ St.; _____ W

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191___, _____
REGISTRAR

MEDICAL CERTIFICATE

DATE OF DEATH _____ (Month)

I HEREBY CERTIFY, that _____, 191___, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date a

The CAUSE OF DEATH* was as follo

_____

_____

_____ (Duration) _____ yr

Contributory _____
(SECONDARY)
_____ (Duration) _____ yr

(Signed) _____

_____, 191___ (Address) _____

*State the Disease Causing Death, or, in deat (1) Means of Injury; and (2) whether Accidental, Suic

LENGTH OF RESIDENCE (FOR HOSPITALS, IN RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

UNDERTAKER

D

AD

Statement of occupation.—Precise statement of occupation is very important, so that the relative health-

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial*