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.

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

PLACE OF DEATH

County Pemiscot

Township ____ or Village Steele or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 655 File No. 2233

Primary Registration District No. 4392 Registered No. 6

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

FULL NAME Martha Gill

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH ____ (Month) ____ (Day), 1845 (Year)

AGE About 78 ~~65~~ yrs. ____ mos. ____ 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) ____

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S T Gill

(ADDRESS) Steele Mo

Filed Jan 16th 1913 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 16th, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw her alive on January 16, 1913, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cancer of the Face

52 (Duration) 2 yrs. ____ mos. ____ ds.

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

(Signed) J M Robbins M. D.

Jan 16, 1913 (Address) Steele 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 Mt Zion Cemetery DATE OF BURIAL Jan 17th 1913

UNDERTAKER C P Howard ADDRESS Steele 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.

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

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

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 OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*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	DATE OF BURIAL
	_____, 191__
UNDERTAKER	ADDRESS