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.

PLACE OF DEATH

County Pettis

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

Dr. Crowe, Ord

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

Registration District No. 668 File No. 23584

Primary Registration District No. 3032 Registered No. 166

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

FULL NAME Martha J Hieronymus

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Singer

DATE OF BIRTH Oct (Month) 7 (Day), 1839 (Year)

AGE 74 yrs. 9 mos. 7 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) — 82 D

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

PARENTS
NAME OF FATHER Francis Hieronymus
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Permelia Bunch
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J F Hieronymus

(ADDRESS) Sedalia

Filed July 15 1914 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 14 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from October, 1912 to July 14, 1914, that I last saw her alive on about Nov 1st, 1913, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

General Parralysis (Paralysis)

66 (Duration) 3 yrs. 4 mos. 10 ds.

Contributory (SECONDARY) Parralysis (Duration) 3 yrs. 4 mos. 10 ds.

(Signed) S G Crawford M. D.

July 16 1914 (Address) 510 Ohio Ave

*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 Crown Hill

DATE OF BURIAL July 17 1914

UNDERTAKER McLaughlin

ADDRESS Sedalia

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 import

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