

PLACE OF DEATH

County BuchananTownship AgencyVillage AgencyCity AgencyMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 80 File No. 23671Primary Registration District No. 4048 Registered No. 19

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

FULL NAME Martha Ann Wallace

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>x</u> <u>widowed</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Nov</u> <u>10</u> , 18 <u>90</u> (Month) (Day) (Year)		
AGE <u>65</u> yrs. <u>8</u> mos. <u>14</u> 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) Housewife

BIRTHPLACE

(City or town, State or foreign country) Buchanan Co. Mo.

PARENTS

NAME OF FATHER

Riley Wilson

BIRTHPLACE OF FATHER

(City or town, State or foreign country) N.C.

MAIDEN NAME OF MOTHER

Elizabeth Rice

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) N.C.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Harry Staggs(ADDRESS) Agency, Mo.Filed 7/24/16 1916 R. F. Owens

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July 24, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 16, 1916, to July 24, 1916, that I last saw her alive on July 23, 1916, and that death occurred, on the date stated above, at 5 P.m.

THE CAUSE OF DEATH* was as follows:

978
1322 Arteriosclerosis 81(Duration) uncertain yrs. mos. ds.

Contributory (SECONDARY)

Uremia(Duration) 0 yrs. 0 mos. 1 1/2 ds.

(Signed)

E. E. Melaney M. D.July 26 1916 (Address) Agency 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

Agency Cem

UNDERTAKER

H. A. Owens

DATE OF BURIAL

7/26/16 1916

ADDRESS

Agency Mo

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

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

County _____

Township _____ or _____
Village _____ or _____
City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____) St. _____ Ward _____

(If death in hospital or give its name of street and _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If like the word)
DATE OF BIRTH _____, 19____, at _____ (Month) (Day) (Year)		
AGE _____, 19____, to _____ (Month) (Day) (Year)		
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)

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 _____, 19____.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 19____, at _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased

that I last saw him _____ alive on _____

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed)

_____, 19____ (Address)

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

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

19____