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 Lewis

Township Salem

or

Village Steffenville

or

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

Registration District No. 485 File No. 24976

Primary Registration District No. 5648 Registered No. .....

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

FULL NAME Martha Holl

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Write the word) Wid

DATE OF BIRTH: Sept - 3rd (Month) (Day), 1827 (Year)

AGE: 88 yrs. 10 mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country): Zanesville, Ohio

PARENTS

NAME OF FATHER: John Logan

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland

MAIDEN NAME OF MOTHER: Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nettie Antrim

(ADDRESS) Steffenville, Mo.

Filed July 6, 1916. J. E. Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July - 5 (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July-1-, 1916, to July - 5, 1916, that I last saw her alive on July - 6, 1916, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - L. lung -

109 A

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (SECONDARY) .....

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

(Signed) F. W. Holl M. D.

July - 6 1916 (Address) Steffenville 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: Steffenville Mo

DATE OF BURIAL: July 6, 1916

UNDERTAKER: Jas T. Coder

ADDRESS: LaBelle Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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

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.