PLACE OF DEATH

County Marion

Township Round Grove

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 551 File No. 2150-a

Primary Registration District No. 5744 Registered No. 1

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

FULL NAME Martha A. English

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: November 22d 1838 (Month) (Day) (Year)

AGE: 79 yrs. 1 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Marion County Mo.

PARENTS

NAME OF FATHER: Abijah Kerrick

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

MAIDEN NAME OF MOTHER: Dulcena Dearing

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis R. English son of the above

(ADDRESS) Maywood Mo.

Filed Feb 6, 1917. J M Cubs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 19th, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 13th, 1917, to Jan 17th, 1917, that I last saw her alive on Jan 17th, 1917, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

8217

(Duration) ___ yrs. ___ mos. 6 ds.

Contributory (SECONDARY) ___

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

(Signed) C W Hamlin M. D.

Jan 20, 1917 (Address) Philadelphia 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: Evergreen

DATE OF BURIAL: Jan 21, 1917

UNDERTAKER: W H Leach

ADDRESS: Maywood

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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

....., *1*.....
(Month) (Day) (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

....., *191*.....
(Month) (Day) (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