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

2520 a

PLACE OF DEATH
County: Phelps
Township:
City: St. James Mo. (No. ..... St. ..... Ward)

Registration District No. 678
Primary Registration District No. 4404

File No. 11
Registered No.

FULL NAME: Martha Ann Favorite

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 14, 1847

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	5	11	

OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Phelps Co. Mo

10. NAME OF FATHER Jacob Lowe

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Eliza Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Do not Know

INFORMANT Emma A. Rogers
(Address) St. Louis, Mo.

FILED 1-25 1917 Mrs. Florence Mallock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 24 1917

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1917, to Jan. 24, 1917, that I last saw h. alive on Jan. 24, 1917, and that death occurred, on the date stated above at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis (Interstitial)

(duration) 1 yrs. — mos. — ds

CONTRIBUTORY (SECONDARY) 1290

(duration) ..... yrs. ..... mos. ..... ds

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. H. Breuer, M. D
1-25, 1917 (Address) St. James, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hickory Grove Cem.
DATE OF BURIAL: 1-25 1917

20. UNDERTAKER: W. E. Licklider
ADDRESS: St. James Mo.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....W

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19
that I last saw h..... alive on....., 19....., an
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDA HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURI

20. UNDERTAKER	ADDRESS