WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Pettis

Township ____ or Village ____ or City Sedalia (NO. ____ St.; ____ Ward)

Registration District No. 668 File No. 2321

Primary Registration District No. 3032 Registered No. 20

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

FULL NAME Juan Martinez

PERSONAL AND STATISTICAL PARTICULARS

SEX W

COLOR OR RACE White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widow

DATE OF BIRTH Unknown (Month) ____ (Day) ____ (Year)

AGE about 50 yrs. ____ mos. ____ ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work Track Labor
(b) General nature of industry, business, or establishment in which employed (or employer) A R M K+T

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

PARENTS
NAME OF FATHER Unknown
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) B H Miller

(ADDRESS) Sedalia Mo

Filed Jan 22 1918 F B Long
per E. J. Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. (Month) 18 (Day), 1918 (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:

Accidental burning
Fell on cinder pile

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

167

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W M Wheeler Coroner M. D.

1-21 1918 (Address) Sedalia 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 Crown Hill

DATE OF BURIAL Jan 20 1918

UNDERTAKER Staley Med Co

ADDRESS Sedalia Mo

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) ..... (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

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