

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

County Stone
 Township Washington
 OR
 Village _____
 OR
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 843 File No. 37503
 Primary Registration District No. 6106 Registered No. _____

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

FULL NAME

Martha Brafford

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE Widowed
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH

Don't Know

(Month) (Day) (Year)

AGE

63

yrs. mos. 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)

Ind?

NAME OF FATHER

Don't Know

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Don't Know

MAIDEN NAME OF MOTHER

Don't Know

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Virginia Taylor

(ADDRESS)

Galena Mo.

Filed

Nov 1, 1918Chenson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

1Oct.281918

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

Oct. 1, 1918, to Oct. 20, 1918,that I last saw her alive on Oct 20, 1918,and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre6 to 8(Duration) Don't Know yrs. mos. ds.

Contributory

(SECONDARY)

(Duration) ✓ yrs. mos. ds.

(Signed)

J. Henson

M. D.

Oct 28, 1918(Address) Galena 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) Stone Co. Poor HouseAt place of death 8 yrs. 8 mos. 8 ds. State 8 yrs. 8 mos. 8 ds.

Where was disease contracted if not at place of death?

Don't Know

Former or usual residence

Mo.

PLACE OF BURIAL OR REMOVAL

Galena Cemetery

DATE OF BURIAL

Oct 28, 1918

UNDERTAKER

W D Mathes

ADDRESS

Galena Mo

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 occurred in hospital or in give its NAME of street and no.

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds. or min.?	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) _____

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) _____

I HEREBY CERTIFY, that I attended deceased _____, 191 _____, to _____, that I last saw him alive on _____ and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT 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 _____