Beaty

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Greene

Township ..... or Village ..... or City Springfield Mo (No. 1098 East Center St.; ..... Ward)

Registration District No. 318 — File No. 39175

Primary Registration District No. 2001 — Registered No. 831

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

2 FULL NAME Martha Grove

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Nov (Month) 8 (Day) 1843 (Year)

7 AGE 75 yrs. — mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housework

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

9 BIRTHPLACE (City or town, State or foreign country) Ind.

PARENTS

10 NAME OF FATHER Albert Varin

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown

12 MAIDEN NAME OF MOTHER Kizia Banty

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Grove

(Address) Springfield, Mo

15 Filed NOV 12 1918 1918 Edwin F. James Registrar

Dallie B. Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 11 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 4, 1918, to Nov. 11, 1918, that I last saw her alive on Nov. 8, 1918, and that death occurred, on the date stated above, at 5:35 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexia.

8211

97

64

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) W. R. Beatie M. D.

Nov 11, 1918 (Address) Springfield Mo.

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL Brighton, Mo — DATE OF BURIAL Nov 12, 1918

20 UNDERTAKER J. W. Klingner & Co — ADDRESS Springfield Mo

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**

NB. Be exact. Show or indication should be carefully supplied. Avoid words as stated. EXACTITUDE IS IMPORTANT. Should they CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.