LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

38415

1 PLACE OF DEATH

County Stone

Township Grant
or
Village
or
City (NO. St.; Ward)

Registration District No. 1068 File No. 19

Primary Registration District No. 6105 Registered No. 12

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

2 FULL NAME J T Martin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

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

6 DATE OF BIRTH Jan (Month) 11 (Day), 1853 (Year)

7 AGE 65 yrs. 10 mos. 23 ds. If LESS than 1 day, ... hrs. or ... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Dallas Co Mo

PARENTS

10 NAME OF FATHER J R Martin

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

12 MAIDEN NAME OF MOTHER Catheryn Martin

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Martin
(Address) Springfield Mo

15 Filed Jan 20 1919 B. F. Smart Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec (Month) 4 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 26, 1919, to Nov 4, 1919, that I last saw him alive on Dec 3, 1919, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:
Bronchs Pneumonia
10 A

91

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

CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. L. Kerr M. D.
12-29, 1919 (Address) Crane

*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 Oak Grove

DATE OF BURIAL 12-5, 1919

20 UNDERTAKER W E Hilton

ADDRESS Crane Mo

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 .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

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

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... 1..... (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) ..... (Day) ..... 191..... (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