5880

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

PLACE OF DEATH

County Polk

Township _____ or Village Humansville Mo or City _____ (NO. _____ St.; _____ Ward)

Registration District No. 703 File No. 1 5880 588

Primary Registration District No. 4424 Registered No. _____

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

FULL NAME Susie Minnervia Martin

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH Sep 6, 1879 (Month) (Day) (Year)

42 6

AGE 42 yrs. 6 mos. — ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS

NAME OF FATHER Isaac W Keller

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

MAIDEN NAME OF MOTHER Susan L. Ball

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G W Jones

(ADDRESS) Humansville Mo

Filed Feb 7, 1922 Helen Beaty Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb (Month) 6 (Day), 1922 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 2, 1922, to Feb 6, 1922 that I last saw her alive on Feb 6, 1922 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the bowels and lungs 23A 25A

(Duration) ___ yrs. 6 mos. ___ ds.

Contributory (Secondary) Influenza

(Duration) ___ yrs. 1 mos. 3 ds.

(Signed) G W Jones MD

Feb 7, 1922 (Address) Humansville 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 Humansville Mo

DATE OF BURIAL Feb 7, 1922

UNDERTAKER L A Joseph

ADDRESS Humansville Mo

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.

M _____ OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or

Village _____ or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____, 1_____ (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 _____, 191____ (Month) (Day) (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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, [illegible]

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