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

1 PLACE OF DEATH

County Lawrence

Township Ozark
or
Village
or
City (NO. , St., Ward)

Registration District No. 1166 File No. 9263

Primary Registration District No. 5638a Registered No.

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

2 FULL NAME Martha Eliza Wheeler

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: not certain (Month) (Day) 1847 (Year)

7 AGE: 75 yrs. 4 mos. ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Near Independence Ark.

PARENTS

10 NAME OF FATHER: William N. Harris

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Giles Co. Penn.

12 MAIDEN NAME OF MOTHER: Mary A Johnson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Giles Co. Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Moore
(Address) Carterton Mo. R.1.

15
Filed 3-14, 1922. Geo. C. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 12, (Month) (Day) 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 5, 1922, to March 12, 1922, that I last saw her alive on March 11, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
10 d

(Duration) yrs. mos. 7 ds.

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

(Signed) Leona J. G. Morrison M. D.
3-13-1922 (Address) Halecomb 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: Dunkle Cemetery
DATE OF BURIAL: 3-13-1922

20 UNDERTAKER: F Kiblinger
ADDRESS: Halcomb 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 ..... 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.]

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) ..... (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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state