

MAR 28 1927

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

Do not use this space.

5345

1. PLACE OF DEATH

County *St. Francois*
Township *St. Francois*
City *Plant & Mine* (No.)

Registration District No. *774*
Primary Registration District No. *44.6.5*

File No. *11*
Registered No.
St. Ward)

2. FULL NAME

Martha E. Fox

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Joseph Fox*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 11, 1884*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *42 4 28*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *House Work* (b) General nature of industry, business, or establishment in which employed (or employer) *at Home* (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Reynolds Co. Mo.*

10. NAME OF FATHER *Wm Asbury*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Reynolds Co Mo.*

12. MAIDEN NAME OF MOTHER *Margaret Keethley*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ny*

14. INFORMANT (Address) *Joseph Fox Plant River Mo.*

15. FILED *Mar. 9 1927* *H. L. Keith* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 9 1927*

17. I HEREBY CERTIFY, That I attended deceased from *July 9 1927* to *July 9 1927*, that I last saw her alive on *July 9 1927*, and that death occurred, on the date stated above, at *10:00 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS: *Exhaustion and Collapse due to prolonged labor with shoulder presentation and uterine inertia*

CONTRIBUTORY (SECONDARY) *Permeation Anemia* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH *145 C 2 1476 718*

B DID AN OPERATION PRECEDE DEATH. DATE OF ... WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *E. R. Schubach*, M. D. *2/10/1927* (Address) *Plant River Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Woodlawn Cemetery* DATE OF BURIAL *2-11-1927*

20. UNDERTAKER *Jos Diemer* ADDRESS *Plant River 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.

