

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

Do not use this space.

1928

7830

**1. PLACE OF DEATH**

County Buchanan  
Township Crawford  
City Wallace (No. Mo)

Registration District No. 83  
Primary Registration District No. 6124

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martha Edwards

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Edwards

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-16-1853

7. AGE YEARS 75 MONTHS 2 DAYS 20 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housekeeping (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY)

10. NAME OF FATHER William Bush

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Gaster Ann Williams

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

14. INFORMANT Martha Edwards (Address) Wallace Mo

15. FILED 37 1928 A. S. Hull REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1928

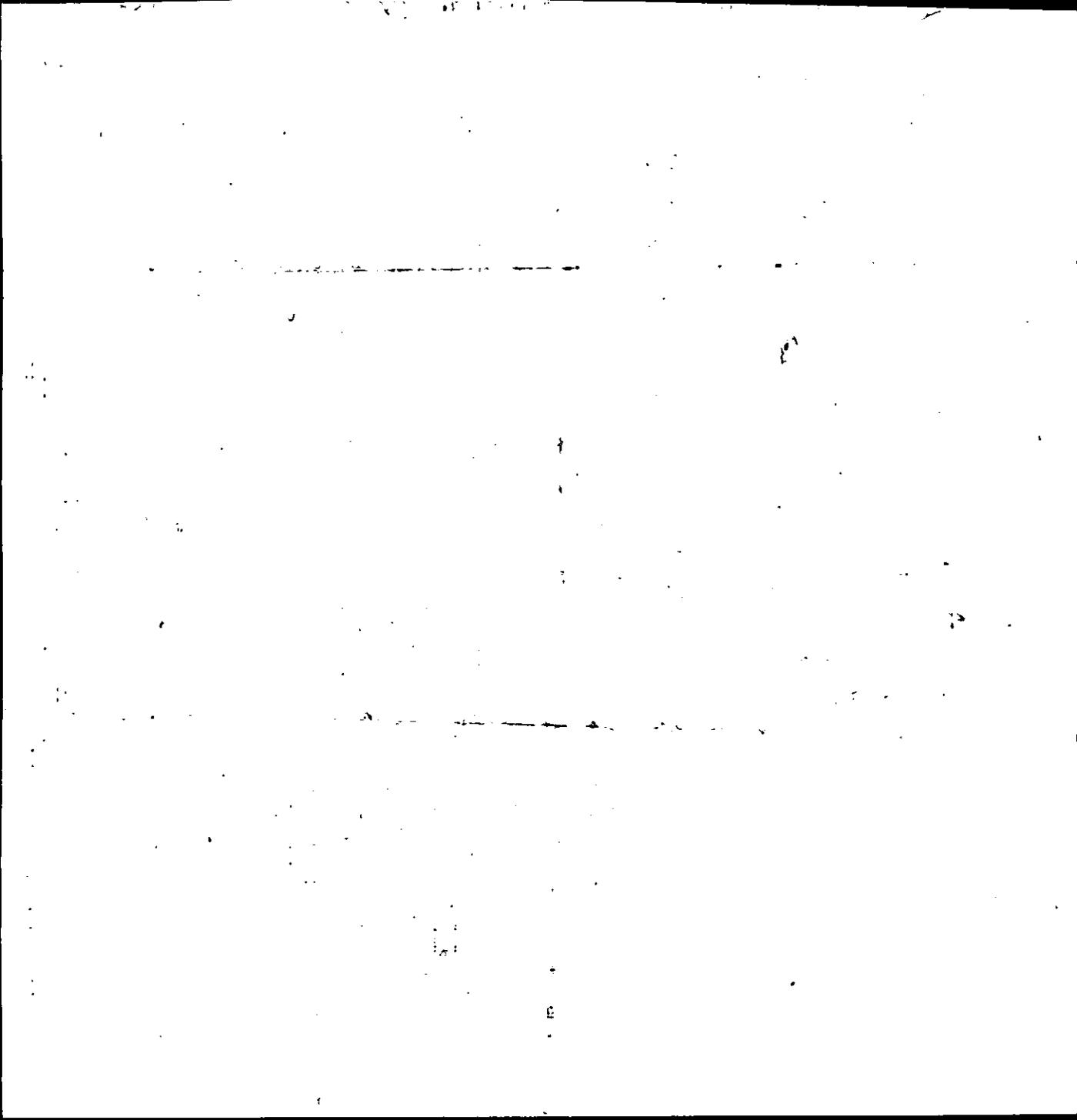
17. I HEREBY CERTIFY, That I attended deceased from Jan 5-8 1928, to March 6 1928, that I last saw h. alive on March 4, 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
chronic nephritis and Arterio Sclerosis  
131  
97 (duration) 5 yrs. mos. da.  
CONTRIBUTORY Endarteritis (SECONDARY) (duration) 5 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED at home IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis  
(Signed) J. K. Peltier, M. D.  
34 1928 (Address) Wallace Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Funeral Home DATE OF BURIAL Feb 8 1928

20. UNDERTAKER E. R. Seidenfaden ADDRESS Wallace Mo



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Buchanan Registration District No. 83 File No. ....  
Township Crowford Primary Registration District No. 5724 Registered No. ....  
City (No. ....) St. .... Ward)

**2. FULL NAME** Martha Edwards  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-16-1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 4 20

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) .....  
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address) .....

15. FILED 37 1928 P. S. Shell REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) mar 6 19 28

17. I HEREBY CERTIFY, That I attended deceased from .....  
to ..... 19....., to ..... 19....., and that  
that I last saw h. .... care of ..... 19....., and that  
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

.....  
..... (duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) .....  
..... (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) ..... , M. D.  
, 19 (Address)

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

ARE COMPLETE AS PRESCRIBED BY LAW

SEE FEE FOR CERTIFICATES

SUPPLEMENTARY

S-7830