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

Do not use this space.

10359

1. PLACE OF DEATH
County St. Francois — Registration District No. 773 — File No.
Township St. Francois — Primary Registration District No. 6018A — Registered No. 40
City ~~Near Farmington~~ (No. ..., ... St. ..... Ward)

2. FULL NAME Martha Wilcox
(a) Residence. No. Hospital No. 4 St., ... Ward. Kennett, Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. 13 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Not known

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): Missouri

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT (Address): Commitment Papers

15. FILED 3-10, 1928. B. J. Robinson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March - 9 - 1928

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1928, to March 9, 1928, that I last saw her alive on March 8, 1928, and that death occurred, on the date stated above, at 1:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia.

10 A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10 A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. R. Brown, M. D.
3-10, 1928 (Address) State Hospital No. 4,

*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: Hospital Cemetery
DATE OF BURIAL: 3-10- 1928

20. UNDERTAKER: None. Hosp. No. 4 Chief Dentist
ADDRESS: Farmington

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.