

28 1928

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

Do not use this space.

21643

1. PLACE OF DEATH

County St. Clair  
Township Royal  
City (No. ....) (St. .... Ward)

Registration District No. 1003  
Primary Registration District No. 1004

File No. ....  
Registered No. ....

2. FULL NAME Martha Ann Pace

(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) widow

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Michael Pace

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/1/1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min. 41

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

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

PARENTS

10. NAME OF FATHER Matthew Francis

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

12. MAIDEN NAME OF MOTHER Mary Allen

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

14. INFORMANT A. J. Francis (Address) Hildemannville, Mo.

15. FILED 8/17/28 G. A. Varnice REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1928, to June 27, 1928, that I last saw her... alive on June 26, 1928, and that death occurred, on the date stated above, at 4:35 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) 11/3 yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH, no. DATE OF.....

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical (Signed) C. L. Landaker, M. D. , 19 (Address) Callins 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 Allen Cemetery DATE OF BURIAL June 29 1928

20. UNDERTAKER Smith ADDRESS Arcola

1000

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County St. Clair  
Township Dayle  
City..... (No. ....) .....

Registration District No. 1005-  
Primary Registration District No. 6009

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Martha Ann Pace

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 19 28

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1841-10-25

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
X 86 X 8 X 2 X

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

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

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)

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 8/17 1928 E. A. Varracey REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

S-21643