

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

Do not use this space.

33614
4800
4154

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Blau Primary Registration District No. 1002 File No. _____
 City Murray City (No. 2935) (Date 10 28) Registered No. 4154 St. _____ Ward _____

2. FULL NAME Martha G. Meek
 (a) Residence. No. 2935-1028 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. 2 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OF RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J.B. Meek

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 22 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 | 5 | 19

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

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

10. NAME OF FATHER Stephen Powers

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

12. MAIDEN NAME OF MOTHER Mimi Lucas

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

14. INFORMANT M. B. Meek (Address) 2935-1028

15. FILED 10/12 28 M. M. Cronin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1928 to Oct 11, 1928 that I last saw her alive on Oct 11, 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis, Chronic
3 yrs (duration) 3 yrs. _____ mos. _____ ds.
 CONTRIBUTORY Pneumonia 1925 (SECONDARY) (duration) 7 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: Pleasant Hill Mo.
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Examination of heart.
 (Signed) M. B. Caselhart - M. D.
10/12 1928 (Address) 1707 Reatts Bldg. R. 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 Thurman La DATE OF BURIAL Oct 12 1928

20. UNDERTAKER Wm. C. L. Lortcher ADDRESS City, Mo.

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.

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**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.....
Township.....
City R. City (No.....) St..... Ward.....

Registration District No. 399
Primary Registration District No. 1002

File No.....
Registered No. 4154

2. FULL NAME

Martha A Meek
(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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.

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 10/12/28 M. M. Kenney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 19 28

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

myocarditis, chronic
pneumonia broncho
CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

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) Milton B. Casper M. D.
, 19 (Address) 1207 K. & Bldg

*State the DISEASE CAUSING DEATH, or in deaths from UNKNOWN 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

19

20. UNDERTAKER

ADDRESS

STATE DEPT. WITH ONWARDING INK--THIS IS A PERMANENT RECORD

N. B. Give 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1880