21 1929
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH
County Callaway — Registration District No. 104 — File No.
Township — Primary Registration District No. 3008 — Registered No. 15
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME Martha Krause Kansas City Mo.
(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. 5 mos. — 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): Unknown

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

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

7. AGE: 61 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

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

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PARENTS
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) —

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14. INFORMANT (Address): Medical Certificate

15. FILED Jan 13, 1929 R. N. Drews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1/13/1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1929, to Jan 13, 1929 that I last saw her alive on Jan 13, 1929 and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralytic Dementia
(Insane)
(duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Lab Clinic.
(Signed) E. E. Tay, M. D.
, 19 (Address) State Hospital

*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.

Fulton Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Kansas City Mo — DATE OF BURIAL: 1/16 1929

20. UNDERTAKER: Herndon Taylor — ADDRESS: Fulton 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.