

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

Do not use this space.

1941 *C*

399

1. PLACE OF DEATH

County *Jackson*
Towaship *Kaw*
City *K.C. Mo*

Registration District No. *1002*
Priority Registration District No. *1002*

File No. *1124*
Registered No. *1124*
St. _____ Ward _____

2. FULL NAME

Martin Lillian
(a) Residence. No. *621 Holmer* St. _____ Ward _____
(Usual place of abode)

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 *colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 19, 1903*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
28 1903 2 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *General Handwork*
(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) *Ark.*

PARENTS

10. NAME OF FATHER *Bert Rogers*

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

12. MAIDEN NAME OF MOTHER *Fisher*

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

14. INFORMANT *Griffith Mathe*
(Address) *3004 Merrier*

15. FILED *3/6 29* 19 *M. M. Crowe* REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-21-1929*

17. I HEREBY CERTIFY That I attended deceased from *1-9-1929* to *1-21-1929* that I last saw her alive on *1-21-1929* and that death occurred, on the date stated above, at *128* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis, Pulmonary
99 298
958
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Cardiac failure*
Ac. Dil. of Heart (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & laboratory*
(Signed) *Howard M. Smith*, M. D.
1/21 1929 (Address) *Old City 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *KC Col Osteo & Surg* DATE OF BURIAL *3/4 29*

20. UNDERTAKER *Mo State Anatomical Board* ADDRESS _____

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.

