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

Do not use this space.

2966

1. PLACE OF DEATH
County Platte — Registration District No. 692 — File No.
Township — Primary Registration District No. 4414 — Registered No.
City Dearborn, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Martha Coyle.
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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 female. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed Wife of James Coyle Deceased

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 7 1840

7. AGE 88 YEARS MONTHS 1 DAYS 12 If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Levy Reynolds.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Kentucky.
12. MAIDEN NAME OF MOTHER Elizabeth Harrass
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Virginia

14. INFORMANT Martha Stafford
(Address) Dearborn, Mo.

15. FILED Jan 28 1929 M. H. Moore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th, 1927, to Jan 21st, 1929 that I last saw her alive on Jan 3rd, 1929, and that death occurred, on the date stated above, at 11.15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Bronchitis
(duration) 5 yrs. X mos. X ds.
CONTRIBUTORY (SECONDARY) Accidental Fracture of Femur (duration) yrs. 9 mos. 29 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? At home
DID AN OPERATION PRECEDE DEATH? No. DATE OF None
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) S. L. Durham, M. D
Jan 21, 1929 (Address) Dearborn 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 Old Frame Cem. DATE OF BURIAL Jan 21 1929

20. UNDERTAKER Lucian Davis ADDRESS Dearborn Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A P... RD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACT... PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

28 1929
83
2
3
235
1
2
2

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 Platte — Registration District No. 692 — File No.
Township — Primary Registration District No. 4414 — Registered No.
City Dearborn (No. ..... St. ..... Ward)

2. FULL NAME Martha Coyle
(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	Wid

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)

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)

14. INFORMANT
(Address)

15. FILED Jan 22, 1929 M H Moore
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 21 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 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:
Chronic Bronchitis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Accidental fracture
Femur fell on high way
(duration) X yrs. X mos. 6 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) ....., M. D
, 19 (Address)

185

10

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

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

5-2966