

**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 Jackson
Township New
City N. E. Mo.

Registration District No. 399
Primary Registration District No. 1002
(No. 2628 Garfield)

File No. _____
Registered No. 832
St. _____ Ward _____

2. FULL NAME

Martha Pittenbarger
(a) Residence. No. 2628 Garfield St., _____ Ward _____
(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) _____

Fe White Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-27-1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>80</u>	<u>1</u>	<u>20</u>	

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)

(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Nathaniel Hill

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) no Record

14. INFORMANT Mr O O Hill

(Address) 2628 Myrandotte

15. FILED 2-19-29 W M Evans REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 17, 1929

I HEREBY CERTIFY, That I attended deceased from Feb 10 1929 to Feb 17 1929 that I last saw her alive on Feb 17 1929, and that death occurred, on the date stated above, at 9:00 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetic gangrene of toe left
foot - diabetes mellitus

57 (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Senile arteriosclerosis (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) at her home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical diagnosis
of Arterio Sclerosis
(Signed) _____ M.D.
Feb 18, 1929 (Address) 509th Withman Bldg

*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 Carthage Mo. DATE OF BURIAL Feb. 20, 1929

20. UNDERTAKER Mrs. C. L. Farster ADDRESS K.C. Mo.

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2 32 5 PM.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 892
 City K. City (No.) St. Ward)

2. FULL NAME

Martha Rittenhouse
 (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 Wid
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 27 - 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 1 20

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 2/19/29 M. M. Bennett REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 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:

..... (duration) yrs. mos. ds.
 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)....., M. D.
 , 19 (Address)

*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

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

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