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

Do not use this space.

7614

**1. PLACE OF DEATH**

County: Polk — Registration District No. 703 — File No.

Township: Johnson — Primary Registration District No. 5932 — Registered No. 32

City: Humansville (No. 111 24 St. Ward)

**2. FULL NAME** Martha J Cauthron

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Widowed |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 13 1855

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 73 | 6 | 23 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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): Mo.

PARENTS

10. NAME OF FATHER: Robert McCracken

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

12. MAIDEN NAME OF MOTHER: Clara Richeson

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

14. INFORMANT: Charles Garland
(Address): Roxbury Kan's

15. FILED 3-4 1929 J. L. Mabry REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929 to Feb 5, 1929, that I last saw h. w. alive on Feb 4 1929, and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Erysipelas of Face
15B
(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (SECONDARY)
(duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. J. Stuffelbeam, M. D.
, 19 (Address) Humansville 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 | DATE OF BURIAL |
|---|---|
| Flemington Mo | Feb 7 1929 |
| **20. UNDERTAKER** | **ADDRESS** |
| R. A. Joseph | 1339 |

# 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: Polk — Registration District No.: 703 — File No.:
Township: Johnson — Primary Registration District No.: 3932 — Registered No.: 32
City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Martha D. Cauthon

(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 | 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: Charles Ireland
(Address) Roxbury, Kansas

15. FILED 3-4, 1929 J. L. Mabry REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 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:
Erysipelas of face
Infected boron face
..... (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

W/B

S-7614