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

Do not use this space.

13665

File No. .....

Registered No. 13

1. PLACE OF DEATH

County: Webster

Registration District No. 896

Township: .....

Primary Registration District No. 4542

City: Marshfield (No. ....., ... St. ..... Ward)

2. FULL NAME Martha M. Calloway

(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: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jas. P. Calloway

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2/24/1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	0	7	

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) Douglas Co. Mo.

PARENTS

10. NAME OF FATHER: D. P. Bruton

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

12. MAIDEN NAME OF MOTHER: Nancy Patterson

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

14. INFORMANT: Guy D Calloway
(Address) Springfield Mo

15. FILED Mar 30 1929. J. W. Bruce
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Mar 1, 1929, that I last saw h. alive on Feb 28, 1929, and that death occurred, on the date stated above, at 1-35 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

(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) J. W. Bruce, M. D.

3/1 1929 (Address) Marshfield 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: Marshfield

DATE OF BURIAL: 3/3 1929

20. UNDERTAKER: N. J. M. Graham

ADDRESS: Marshfield

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD