

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

Do not use this space.

27.1929

10 19167

1. PLACE OF DEATH
 County Johnson Registration District No. 479
 Township Washington, Primary Registration District No. 6554
 City (No.) St. (Ward)

2. FULL NAME Sophrono Elizabeth Martin
 (a) Residence No. Washington Twp St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 36 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Robert Martin
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July, 4. 1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 8 27
 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) Kentucky
 10. NAME OF FATHER James Francis
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown,
 12. MAIDEN NAME OF MOTHER Unknown,
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown.

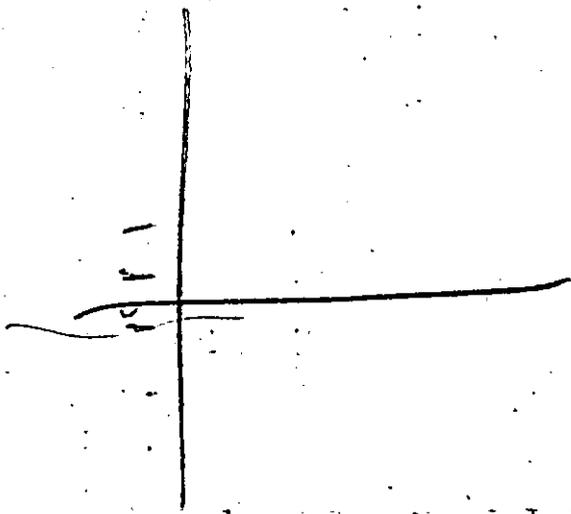
14. INFORMANT Mrs. Minnie L. Higginbotham
 (Address) Sweet Springs, Mo.

15. FILED 4/2 1929 J. Koeh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4
 16. DATE OF DEATH (MONTH, DAY AND YEAR) April, 1 1929
 17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to April 1, 1929 that I last saw h. m. alive on April 10-30 P 1929 and that death occurred, on the date stated above, at m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
1 Valvular Disease
186 A
1003
131 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) 1 Chr. nephritis
2 Fractured Hip (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?
 9 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) W. H. Hoovey, M. D.
 , 19 (Address) Knobnoster 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
Knobnoster Cemetery April 13 19 29
 20. UNDERTAKER ADDRESS
S. R. Sweeney, Warrensburg.

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A handwritten number '1111' is written vertically. A vertical line is drawn through the center of the number. A horizontal line is drawn across the middle of the vertical line, intersecting it. The horizontal line extends to the left and right of the vertical line.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Johnson Registration District No. 429 File No. _____
 Township Washington Primary Registration District No. 2-3-84 Registered No. 10
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Josephine Elizabeth Martens
 (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*) _____

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 4/2, 19 70 code REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ ally (on) _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Internal disease
 _____ (duration) _____ yrs. _____ mos. _____ ds. X
 CONTRIBUTORY (1) Chronic Nephritis
 (SECONDARY)
 (2) Fractured hip due to fall on
 _____ (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? 185 _____

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 _____

20. UNDERTAKER _____ ADDRESS _____

S-15157