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

Do not use this space.

17969 Dr Nickerson

File No. ____

Registered No. 177

1929

1. PLACE OF DEATH

County Jackson — Registration District No. 398

Township Blue — Primary Registration District No. 3019

City Independence (No. ____, ____ St. ____ Ward)

2. FULL NAME Martha Adline Smith Clinton

(a) Residence. No. 1512 W College 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: G. B. Clinton

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 16 1856

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
73	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home 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): Jackson County Tenn

PARENTS

10. NAME OF FATHER: Thomas Smith

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

12. MAIDEN NAME OF MOTHER: Violet Gaw

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

14. INFORMANT: J. R. Warren
(Address) 1513 W. College St.

15. FILED 5-6 1929 F. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1929, to May 4, 1929, that I last saw h. alive on May 4, 1929, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Septicemia ____ (duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (SECONDARY): Infection of puncture wound of thumb due to rose briar ____ (duration) ____ yrs. ____ mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH ✓

2 DID AN OPERATION PRECEDE DEATH? yes DATE OF May 3

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) J. C. Hutchison, M. D.

May 6, 1929 (Address) Indep. 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: Wood Lawn — DATE OF BURIAL: May 6 1929

20. UNDERTAKER: Ott and Mitchell — ADDRESS: Independence Mo

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