

X. 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.

JUN 27 1929

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

Do not use this space.

19071

1. PLACE OF DEATH

County Polk Registration District No. 703
 Township Johnson Primary Registration District No. 5932
 City Humansville No. 4424 St. _____ Ward _____

2. FULL NAME

Martha E Moberly
 (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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 24 1846</u>		
7. AGE YEARS <u>82</u>	MONTHS <u>10</u>	DAYS <u>3</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) N. Car.
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>James R. Linn</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	12. MAIDEN NAME OF MOTHER <u>unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT Mrs Eliza Hopper
 (Address) Humansville Mo.

15. FILED 5-28-29 J. L. Mabry
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1929
 17. I HEREBY CERTIFY, That I attended deceased from May 21 1929, to May 27 1929 that I last saw h. ea alive on May 27 1929 and that death occurred, on the date stated above, at 11:35 a m.

11B THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
 (duration) _____ yrs. _____ mos. 6 ds.
 CONTRIBUTORY (SECONDARY) 11B
 (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS clinical exam
 (Signed) R. O. Meunier, M. D.
May 28 1929 (Address) Humansville

*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 city Cemetery DATE OF BURIAL May 29 1929
 20. UNDERTAKER R. A. Joseph ADDRESS 3149

