

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

Do not use this space.

22423

**1. PLACE OF DEATH**

County St. Francois Registration District No. 773  
 Township St. Francois Primary Registration District No. 6078A  
 City Near Farmington, Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 101  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mart Lanham

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (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.  
 (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE. <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about 36</u>	<u>0</u>	<u>0</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Richwoods  
 (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>

14. INFORMANT Hospital Records  
 (Address) Farmington, Mo.

15. FILED 6-20-29 B. J. Robinson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-17 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to 6-17, 1929 that I last saw him alive on 6-17, 1929, and that death occurred, on the date stated above, at 6:30 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis  
9.3 A  
0.5  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Epilepsy  
 (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 Cheval + Seb.  
 (Signed) P. J. Fain, M. D.

6-19, 1929 (Address) Hosp # 4 Farmington 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

Hospital Cemetery 6-20 1929

20. UNDERTAKER ADDRESS  
Hospital No. 4 C. Douber Farmington

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

**JUL 27 1929**  
**94**  
 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.

**250**  
**1**  
**2**

