

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

Do not use this space.

30047

**1. PLACE OF DEATH**

County Bourne  
Township Cedar 1  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 71  
Primary Registration District No. 5110

File No. \_\_\_\_\_  
Registered No. 26

**2. FULL NAME**

Child unnamed Martin

(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 Male 4. COLOR OR RACE White 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.
			<u>9</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Baby  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) McBride mo  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Lloyd Martin

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

12. MAIDEN NAME OF MOTHER Margie Casner

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

14. INFORMANT H. B. Popper MD  
(Address) Ashland, Mo.

15. FILED 70-1-29 A. J. Nichols  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 19 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-7 1929 to Sept 19 1929 that I last saw him alive on Sept 18 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: 1574

Premature birth  
1619 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.  
CONTRIBUTORY Perinatal embolism  
(SECONDARY) and (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? Yes. DATE OF Sept. 17-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? diurnal

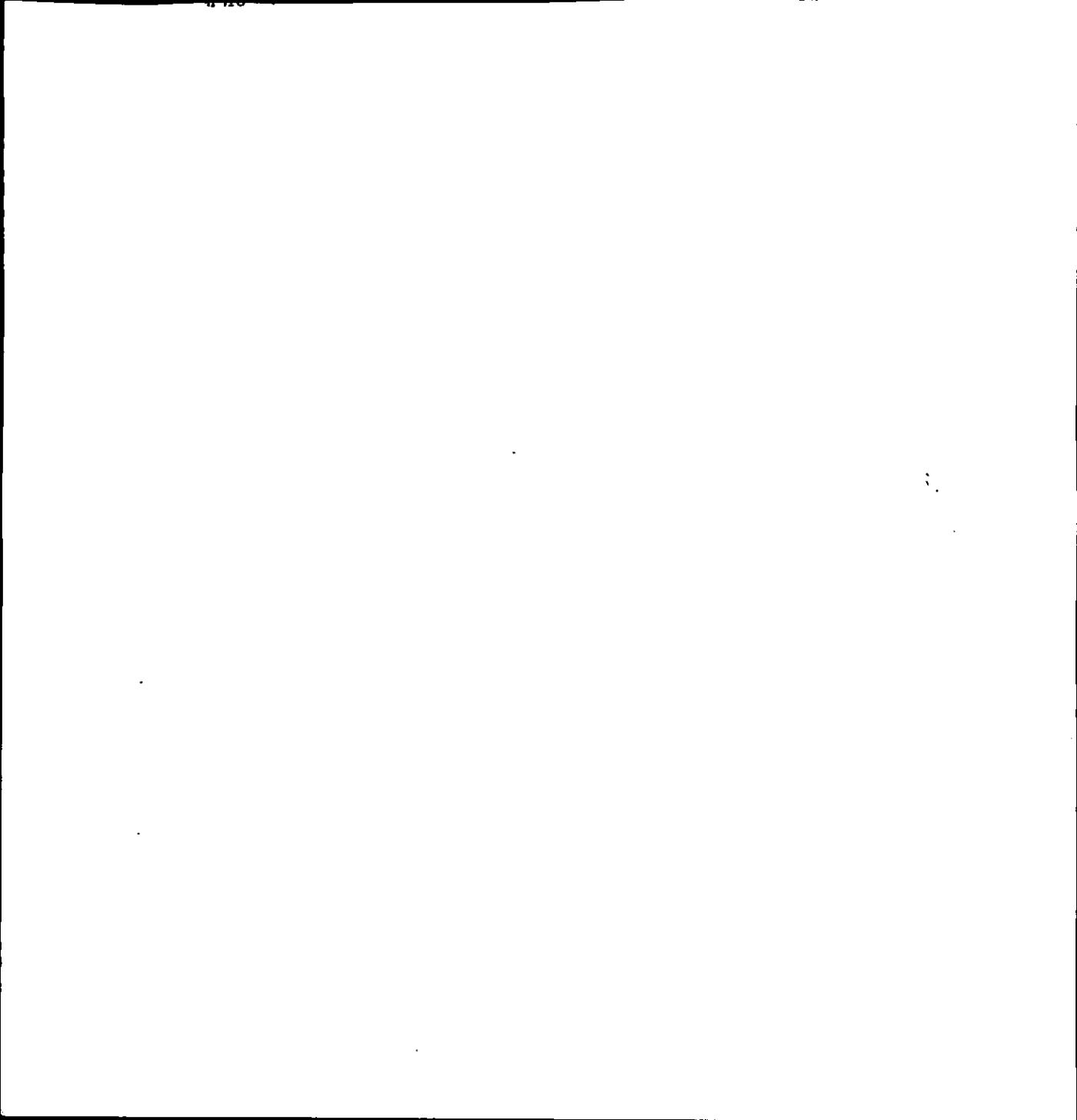
(Signed) H. B. Popper M. D.

Sept 19 1929 (Address) Ashland 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 Nashville DATE OF BURIAL 20 19 29

20. UNDERTAKER Parke Co ADDRESS Salisbury Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH *Boone*  
 County.....*Boone*..... Registration District No. *41*  
 Township.....*Cedar*..... Primary Registration District No. *5110*  
 City..... (No. ....), St. .... Ward)  
 2. FULL NAME *unnamed Martin*  
 (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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *S*  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 16 - 29*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hr. or .....min.  
*9*

**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).....

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 *9-29-29* *R. J. Nichols* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 19 1929*

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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)....., 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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30047