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

Do not use this space.
31527
28522

PLACE OF DEATH

County: Pemiscot
Township: Holland
City: ~~Holland~~ (No. ..... St. ..... Ward)

Registration District No. 656
Primary Registration District No. ~~[illegible]~~ 628

File No.
Registered No.

2. FULL NAME Martha Richmond

(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 6 yrs. mos. ds. How long in U. S., if of foreign birth? ~~[illegible]~~ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	negro	widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1827

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
102			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper
(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): Don't Know

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT: Eligh Thompson
(Address): Holland Mo

15. FILED 10-10, 1929 James A Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-28-9-28 1929

17. I HEREBY CERTIFY, That I attended deceased from 8-28-, 1929, to 9-28-, 1929 that I last saw h~~e~~ alive on 8-30-, 1929, and that death occurred, on the date stated above, at 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Insufficiency
93D (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH X
DID AN OPERATION PRECEDE DEATH? no DATE OF X
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? X

(Signed) L. G. Cooper, M. D.
10-4-, 1929 (Address) Caruthersville 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
Holly Grove Steele Mo	9-29 1929
20. UNDERTAKER	**ADDRESS**
German and Son	Steele Mo

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

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.