

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

Do not use this space.

36156

1. PLACE OF DEATH

County..... Franklin Registration District No..... 983
 Township..... Franklin Primary Registration District No..... 4845
 City..... Franklin City (No. 4845 St. 0 Ward)

2. FULL NAME

Sarah Camelia 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 (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James S. Martin
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 12, 1857
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 1 11 0 0 0

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) " "
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Don't know
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER John Fitzgerald
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY) Massachusetts
 12. MAIDEN NAME OF MOTHER Marion Williams
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Windsor
 (STATE OR COUNTRY) Missouri

14. INFORMANT Samuel E. Martin
 (Address) Denver, Missouri

15. FILED 11/10/29 John Andrews
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1929
 17. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Oct 23, 1929, (that I last saw her alive on Oct 23, 1929, and that death occurred, on the date stated above, at 7 a.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage or apoplexy

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF ...
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Geo. Shippo, M. D.
 (Address) Franklin City, 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 Allendale Cemetery DATE OF BURIAL 10/24/29
 ADDRESS Franklin City

20. UNDERTAKER Arch. C. Dunfee
 ADDRESS Franklin City, Mo.

No. Be-... 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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

10-71

1. PLACE OF DEATH
 County Yonkers Registration District No. 903 File No.
 Township Grand City Primary Registration District No. 4843- Registered No. 21
 City Grand City (No.) St. Ward)

2. FULL NAME Sarah Cornelia Martin
 (a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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.
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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)

PARENTS

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

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

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

SUPPLEMENTARY

WRITE PERMIT
 Every item of information should be supplied. AGE should be stated EXACTLY. SEX should be stated EXACTLY. RACE should be stated EXACTLY. OCCUPATION should be stated EXACTLY. PLACE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. Exact statement of PLACE OF DEATH is very important. Exact statement of SEX is very important. Exact statement of RACE is very important. Exact statement of OCCUPATION is very important. Exact statement of PLACE OF DEATH is very important.

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15. FILED 12/10/29 John Anderson
 REGISTRAR

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