

Dr. Williams' Pills

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

Do not use this space.

37941

1. PLACE OF DEATH

County Madison Registration District No. 625
Township South Primary Registration District No. 3031
City Maryville (No. _____) St. _____ Ward _____

File No. _____
Registered No. 101

2. FULL NAME Martha Jane Masters

(a) Residence. No. 722 Williamson 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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female white Widowed

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

Frank Masters

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 3, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65 5 1

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) Adams County, Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Renshaw

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

12. MAIDEN NAME OF MOTHER Nancy E. Hogan

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

14. INFORMANT Wm. Renshaw
(Address)

15. FILED 11-5-29 C. P. Fryer REGISTRAR
M.E.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 2 1929

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1928, to Nov 2, 1929
that I last saw him alive on Nov 2, 1929, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Stomach
H.B.

CONTRIBUTORY (SECONDARY) H.B.
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Same

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Clinical

(Signed) H. M. Hall Jr. M. D.

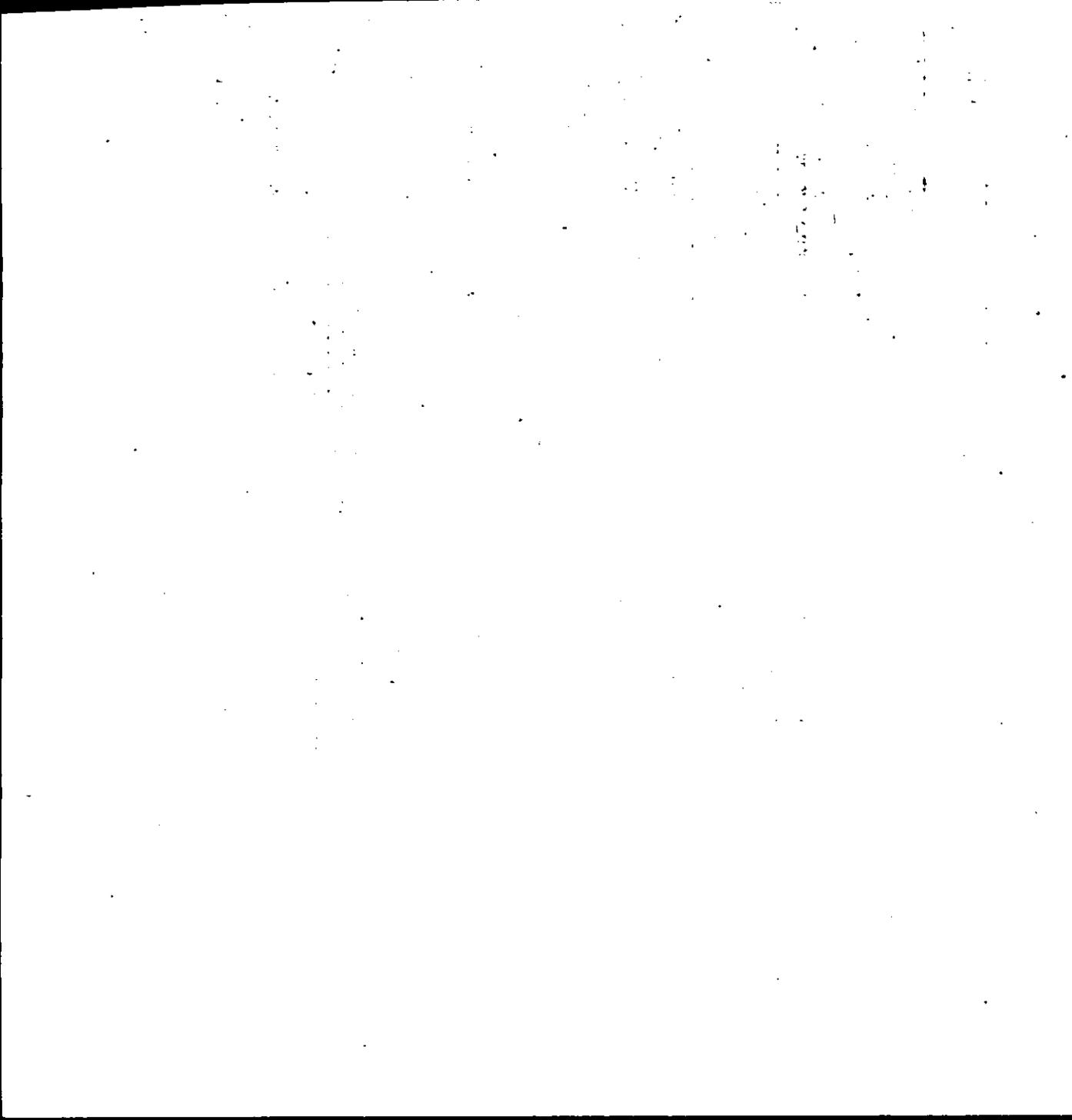
, 19 _____ (Address) Maryville Mo

*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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Miriam Cemetery Nov. 4 1929
22. UNDERTAKER ADDRESS

Price Furniture Co.



**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
 County Holaway Registration District No. 625 File No. _____
 Township _____ Primary Registration District No. 3031 Registered No. 101
 City Maryville (No. _____) St. _____ Ward _____

2. FULL NAME Martha Jane Masters
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 3-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 7 29

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) _____

15. FILED 11-5-29 C. P. Fryer REGISTRAR
m.e.c.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 1929

17. I HEREBY CERTIFY That I attended deceased from _____
 19____ to _____, 19____
 that I last saw h. _____ 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 _____
 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

S-37941