

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

Do not use this space.

4505

1. PLACE OF DEATH

County Dallas Registration District No. 243
 Township Sheldon Primary Registration District No. 1
 City Fair Grove (No. _____) St. _____ Ward _____

2. FULL NAME Lula B. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-11-1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 0 0

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) Dallas Co. Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Marshall Martin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pleasant Hope Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Matha Seagy

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

14. INFORMANT Charles Martin
 (Address) Fair Grove

15. FILED 2/10/30 M V R REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4-30

17. I HEREBY CERTIFY, That I attended deceased from 6-1-1928 to 2-4-1930, 1930 that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at 26.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 23A
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED place of death
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS usual
 (Signed) H. Plummer, M. D.
 _____, 19 (Address) Buffalo 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 Union Ground DATE OF BURIAL 2-5-30

20. UNDERTAKER W. B. Jones ADDRESS Buffalo Mo

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Dallas Registration District No. 243 File No. _____
 Township Shendon Primary Registration District No. 3-337 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Lula B. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) S

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1930

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

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 signed above, at _____m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1902

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hrs. or _____min.
27 2 23

CONTRIBUTORY (SECONDARY) (duration) _____yrs. _____mos. _____ds.

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 _____

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.

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

19

10. NAME OF FATHER _____

20. UNDERTAKER _____

ADDRESS _____

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 4/10 1930 M V. Rea REGISTRAR

SUPPLEMENTARY

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

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