DEC 23 1930

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

Do not use this space.

37335

1. PLACE OF DEATH
County: St Louis
Township: Central
City: Richmond Heights
Registration District No.: 1170
Primary Registration District No.: 6 24 8 8
No.: St. Marys Hospital
File No.:
Registered No.: 267
St. Ward)

2. FULL NAME: Margaret M. Martin
(a) Residence. No. 432 M. Big Bend Rd St., Ward. Webster Groves Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 8 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 (write the word): Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Charles H. Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR): about 1850

7. AGE: Years: about 80 | Months: | Days: | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House-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): New York

PARENTS
10. NAME OF FATHER: Daniel B. Wasson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): New York
12. MAIDEN NAME OF MOTHER: Sarah Borden
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mass.

14. INFORMANT: Martin B. Wasson 432 M. Big Bend Webster Groves Mo
(Address)

15. FILED 11/12 1930 C. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11-11 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 11, 1930 that I last saw h. alive on Nov 11, 1930, and that death occurred, on the date stated above, at 6:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Melanoma — skin of neck
// metastases to mediastinum
549
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Secondary anemia
(duration) yrs. 6 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) R. A. Russella M.D.
11/12/1930 (Address) 415 Beaumont Bldg

*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: Bellefontaine Cemetery
DATE OF BURIAL: Nov 14 1930
20. UNDERTAKER: Louis H. Bopp
ADDRESS: Kirkwood Mo.

N. B.—Every item 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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St Louis Registration District No. 1170 File No.

Township Primary Registration District No. 6248 Registered No. 267

City Richmond Heights (No. ..... St. ..... Ward)

2. FULL NAME Margaret 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 F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Wid

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.

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 1/6 1931 C L Jensen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/11 1930

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:
Melanoma - Skin
Neck, metastasis to
mediastinum -
Malignant - (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Secondary anemia
(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

N. B. ... should be carefully supplied. AGE should ... PHYSICIANS ... CAUSE ... so that it may be properly classified. ... OCCUPATION is very important.

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

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