

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.

OCT 22 1931

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

Do not use this space.

30908

1. PLACE OF DEATH

County DentRegistration District No. 286Township SalemPrimary Registration District No. 416XCity Salem (No. _____)

File No. _____

Registered No. 51

St. _____ Ward _____

2. FULL NAME

Martha Jane Baines

(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. 17 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 (write the word)

widow

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

John A Baines

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

June 18-1848

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

83226

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)

(STATE OR COUNTRY)

Illinois

10. NAME OF FATHER

Andrew Lewis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Mary A McDonald

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT

(Address)

Wm BainesSalem, Mo

15.

FILED

9/15-31 H. E. Knudsen, Jr., L.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

9-14-1931

17.

I HEREBY CERTIFY, That I attended deceased from _____

to _____, 1931, to _____, 1931

that I last saw her alive on _____, 1931, and that

death occurred, on the date stated above, at _____, m. ..

THE CAUSE OF DEATH* WAS AS FOLLOWS

Cerebral Hemorrhage82A162 (duration) yrs. _____ mos. 0 ds.

CONTRIBUTORY (SECONDARY)

Fertility

(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.

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

Baines Graveyard9/15-1931

20. UNDERTAKER

H. D. Holman

ADDRESS

Salem, Mo

