

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

Do not use this space.

13082

1. PLACE OF DEATH  
 54 County Lafayette etc Registration District No. 466  
 10 Township Wellington Primary Registration District No. 14279  
 3 City Wellington (Non) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Lillian Louise 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 7-1901

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>28</u>	<u>8</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brooklyn New York

MOTHER FATHER

13. NAME Jacob Seibert

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Lea Swanderlick

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bohemia

17. INFORMANT Thomas Martin (ADDRESS) Wellington Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wellington Mo DATE April 28 1932

19. UNDERTAKER (ADDRESS) Edgestreet Mo

20. FILED April 18 1932 Registrar F. H. Mann

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18 1932

22. I HEREBY CERTIFY, That I attended deceased from April 10 1932 to April 18 1932  
 I last saw her... alive on April 15 1932 Death is said to have occurred on the date stated above, at 10:00 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Heart Clot Date of onset 4/14/32  
12/14/31  
50B / 44B  
 Other contributory causes of importance: Post Partum Hemorrhage 4/9/32

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chemical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) F. H. Mann M. D.  
 (Address) Wellington Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHISICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. MAY 25 1932

1700  
1700

1700  
1700

1700  
1700

1700  
1700

**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 Rosette  
Township \_\_\_\_\_  
City Wellington (No. \_\_\_\_\_)

Registration District No. 466  
Primary Registration District No. 279

File No. \_\_\_\_\_  
Registered No. 9  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 18, 1932

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 1 - 1901

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS 31 MONTHS \_\_\_\_\_ DAYS 17 If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

13. NAME \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Nature of injury \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

20. FILED Apr 18, 1932 F. W. Mason Registrar.

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

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

SUPPLEMENTARY

5-13082