

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

Do not use this space.

13754

**1. PLACE OF DEATH**

96 County St. Louis Co. Registration District No. 784  
 Township St. Ferdinand Primary Registration District No. 6030  
 City Ferguson (No. 149) Adelle Pl. St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martin Christensen  
 (a) Residence, No. 149 Adelle Pl. 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**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Elizabeth Christensen</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11</u>		
7. AGE YEARS <u>56.</u>	MONTHS <u>0.</u>	DAYS <u>3.</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Cabinet maker</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Self</u>	
	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) Rockford Ill. 2

FATHER 13. NAME Unknown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Norway 24

MOTHER 15. MAIDEN NAME Unknown

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Norway

17. INFORMANT Elizabeth Christensen (ADDRESS) 149 Adelle Pl.

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla, Grm. DATE April 13, 1932

19. UNDERTAKER Cambruster, Und & Co (ADDRESS) 4234 Manchester Ave.

20. FILED 572 1932 Emm J. Harris Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 10 1932

22. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1932 to April 10 1932. I last saw him alive on April 10 1932. Death is said to have occurred on the date stated above, at 11:55 a.m.

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

Carcinoma of liver Date of onset \_\_\_\_\_

40E 46 6 1

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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? If so, specify \_\_\_\_\_

(Signed) A. Leggat, M. D.  
 (Address) Ferguson Mo

THIS IS A PERMANENT RECORD

Every death certificate filed with the Board of Health is a permanent record. 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.

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**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 St. Louis Registration District No. 784  
Township St. Ferdinand Primary Registration District No. 6030  
City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Martin Christensen  
(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 7, 1876</u>		
7. AGE YEARS <u>56</u>	MONTHS <u>-</u>	DAYS <u>3</u>
		If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

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

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

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

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

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

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

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

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

20. FILED 5/2 1932 Emma J. Harris Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10 1932

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

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

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

Date of onset

Other contributory causes of importance:

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

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

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

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

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

**SUPPLEMENTARY**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

7 lines  
N. B.—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. REGISTER. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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