

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

Do not use this space.

19363

**1. PLACE OF DEATH**

41 County Harrison Registration District No. 387 File No. ....  
 Township Myrtle Primary Registration District No. 5543 Registered No. ....  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

Emeline 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 (write the word) Widowed

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.
	87	6	5	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer) -  
 (c) Name of employer Marcus Co. Penn

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 31

PARENTS

10. NAME OF FATHER Ringer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Penn. 2

12. MAIDEN NAME OF MOTHER none

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

14. INFORMANT Mrs. R. L. Linder  
 (Address) Korthkornong Mo

15. FILED July 4, 1932 H. H. Thompson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 7 - 1932

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., and that I last saw h. .... alive on ..... 19....., and that death occurred, on the date stated above, at ..... 3-0..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Sensibility  
1162  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10 1/2  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH..... 9

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

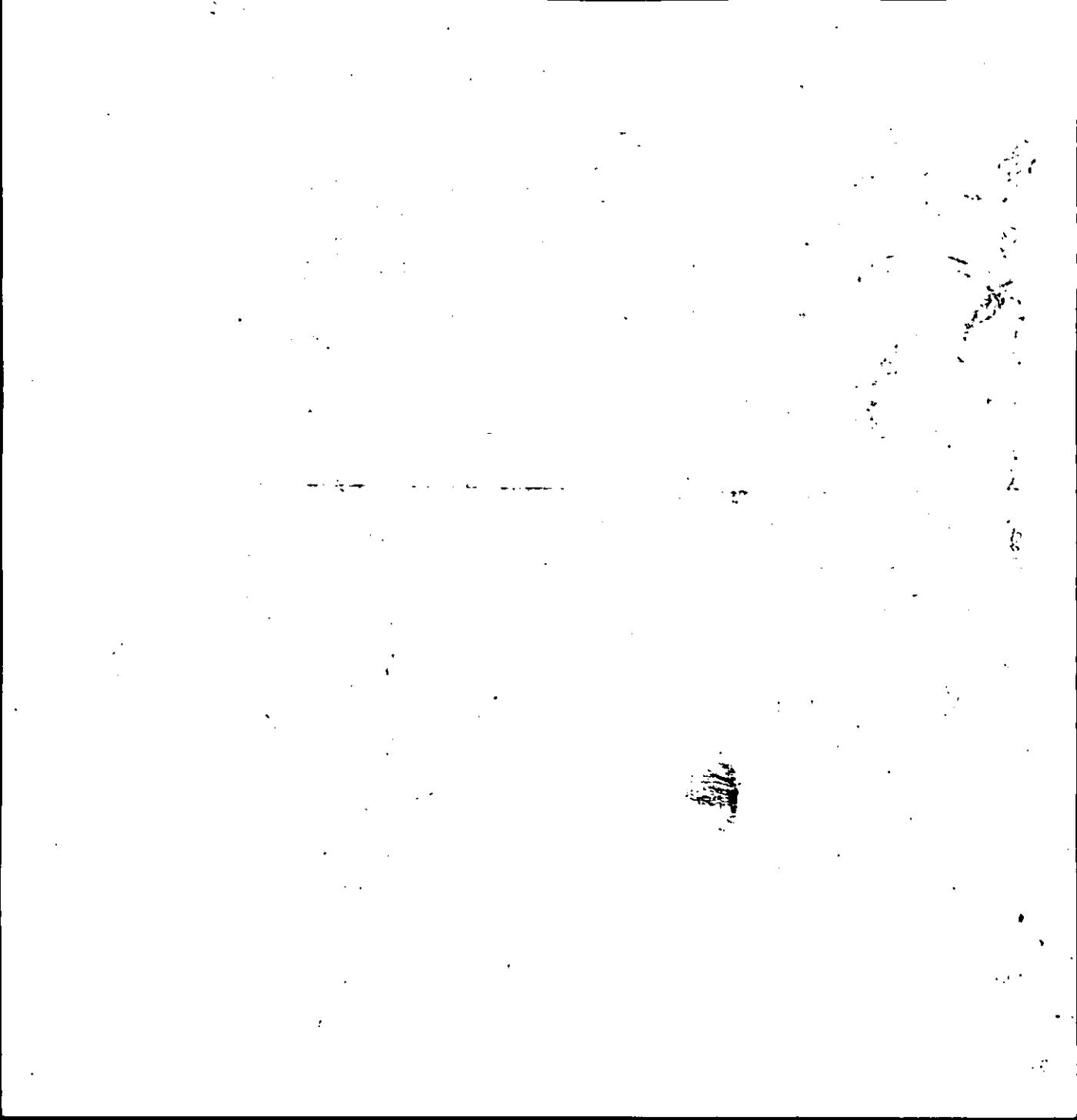
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) No doctor in attendance, M. D.  
 , 19 (Address) attendance

\*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 Korthkornong Mo DATE OF BURIAL 6/8 - 1932

20. UNDERTAKER Chas Jones (acting) ADDRESS Korthkornong Mo



**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 Howell  
Township Myrtle  
City                      (No.                      St.                      Ward                     )

Registration District No. 389  
Primary Registration District No. 3543

File No.                       
Registered No.                     

**2. FULL NAME**

Emeline 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) Dec 2 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
87 6 5

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

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                      19                     

Registrar                     

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7 1937

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

I last saw h                      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**

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

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