

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

Do not use this space.

28958

1. PLACE OF DEATH

County Gentry
Township
City Albany (No. _____)

Registration District No. 309
Primary Registration District No. 4185

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Francis Leata 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) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 22 1914

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
18 6 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

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) Albany Mo.

FATHER 13. NAME John Martin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gentry Mo.

MOTHER 15. MAIDEN NAME Ethel Coffey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gentry Mo.

17. INFORMANT (ADDRESS) Richard Coffey Albany, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Sept. 26, 1932

19. UNDERTAKER (ADDRESS) Art. Bazel Albany Mo.

20. FILED Sept 26 1932 W.T. Martin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24, 1932

22. I HEREBY CERTIFY, That I attended deceased from Sept 24, 10^o AM 1932, to 9 PM 24, 1932

I last saw her alive on Sept 24 9 PM, 1932. Death is said to have occurred on the date stated above, at 11 P. m.

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

1 Pneumonia Left Lung Date of onset Sept 20

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) W.M. White _____, M. D.

(Address) Albany Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 15 1932

STATION
NO. 10

STATION
NO. 10

STATION
NO. 10

**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 Sentry
Township Albany
City Albany (No. _____)

Registration District No. 309
Primary Registration District No. 4185

File No. _____
Registered No. 47
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

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

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.
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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. FILE NO. Nov. 12 1932 W. T. Martin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24, 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:

Suppurative pneumonia of left lung (Date of onset _____)

Bronchopneumonia

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

1070

B.—Item of information should be care. USE DATE in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CER. TIES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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