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

Do not use this space.

12941

1. PLACE OF DEATH

County: Greene — Registration District No.: 317 — File No.:

Township: Republic — Primary Registration District No.: 5436 — Registered No.:

City: (No. , St. Ward)

2. FULL NAME Martha Ellen Hagerwood

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 24th 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	74	2	4	

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) Tenn.

PARENTS

10. NAME OF FATHER John Goodin

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

12. MAIDEN NAME OF MOTHER Tamsie Davis

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

14. INFORMANT Dallie R. Manley
(Address) Springfield Mo.

15. FILED 4-30, 1933 T. W. Sliver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1933

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1932, to April 17, 1933, that I last saw h. on alive on April 17, 1933, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Malignant Lesion of the Heart. Gallbladder Surgical Drainage
72 h (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH At Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. S. Smith, M. D.
, 19 (Address) Republic Mo.

*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
Lindsey Chapel	4-30 1933
20. UNDERTAKER	**ADDRESS**
A. S. Wallace	Billings Mo.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MAY 22 1933