

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.

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

Do not use this space.

28804

SEP 14 1934

1. PLACE OF DEATH
 County Allen Registration District No. 241 File No. _____
 Township W. Benton Primary Registration District No. 2434 Registered No. 919
 City Buffalo (No. 13) St. _____ Ward _____

2. FULL NAME Martha Josephine Sheridan
 (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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>77</u>	<u>2</u>	<u>1</u>	

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

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) Ind

FATHER 13. NAME Thomas Hale

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) Jos. A. Sheridan Buffalo Ind

18. BURIAL, CREMATION, OR REMOVAL PLACE Schepell's DATE 8-8 1934

19. UNDERTAKER (ADDRESS) H. B. Jones Buffalo Ind

20. FILED 9/10 BY Hannay Moran Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-6, 1934

22. I HEREBY CERTIFY, That I attended deceased from 8-1, 1934 to 8-6, 1934
 I last saw her alive on 8-5, 1934 Death is said to have occurred on the date stated above, at 2 A.M.
 The principal cause of death and related causes of importance were as follows:

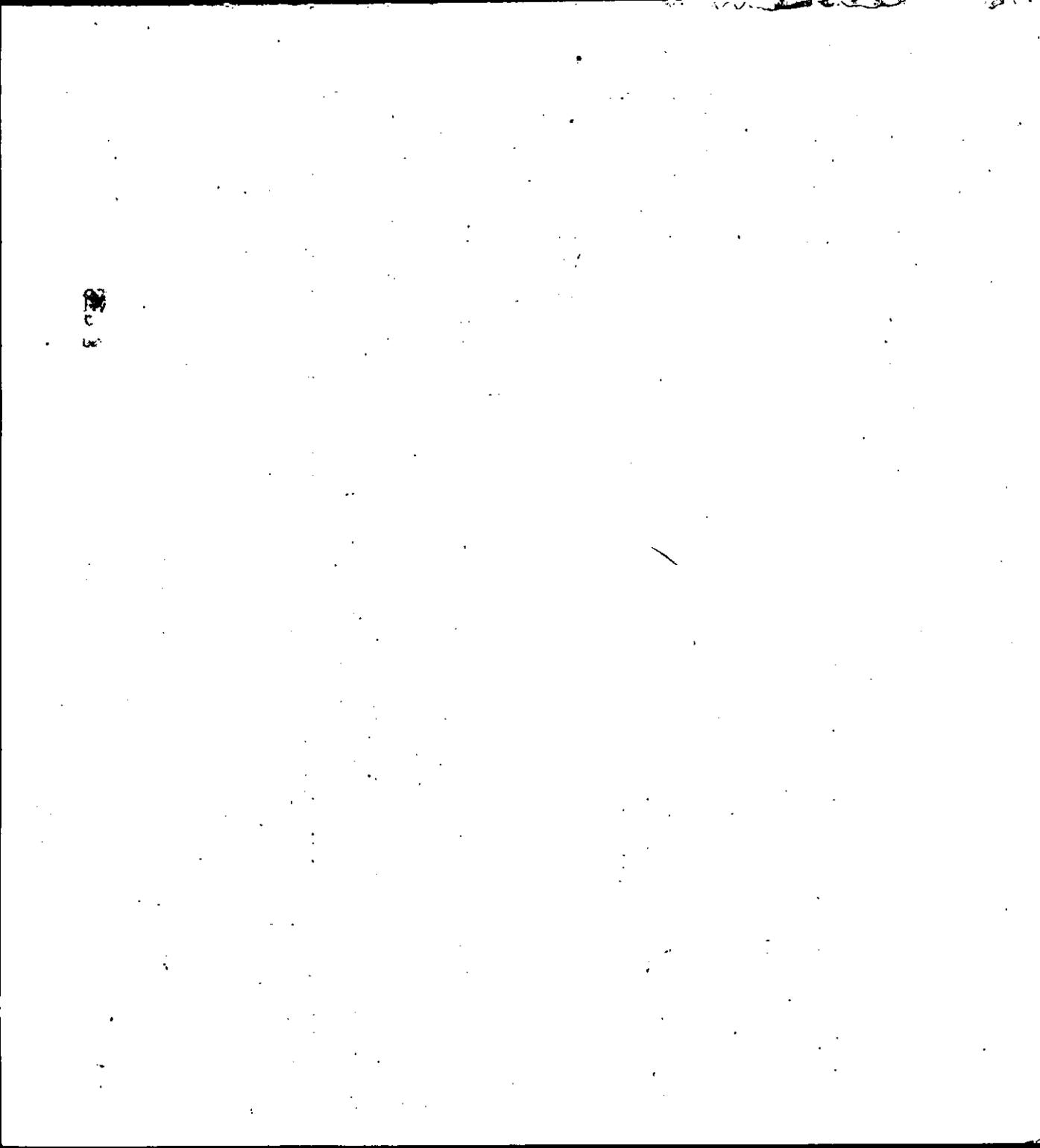
Acute Sclerosis Date of onset _____
1326
 Other contributory causes of importance:
Nephritis, uremia 8-1-34

Name of operation _____ Date of _____
 What test confirmed diagnosis? usual 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) H. B. Jones, M. D.
 (Address) Buffalo Ind



919

Dallas

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Martha Josephine Sheridan
Who died at _____ on Aug 6 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex f Color or race W Single, married, widowed or divorced: _____

Date of birth June 5 1887 Age: Years 47 Months 2 Days 1

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

~~Artists releases~~ Werner
Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) republic of France
Birthplace of mother (State or country) France
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

X Signature of Registrar Haney Morrow Date filed _____
This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. 41st. No. 241

Primary Reg. 41st. No. 5334

Very truly yours,

E. J. McCaugh M.D.
gc

Special Agent.

S-28804