

AUG 19 1935

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

Do not use this space.

1. PLACE OF DEATH

County Macon
Township Liberty
City _____ (No. _____) St. _____ Ward _____

Registration District No. 533
Primary Registration District No. 5715

File No. 23695
Registered No. 188

2. FULL NAME

Martha Jane Smith
(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 Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D.K.

7. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 3rd 1834

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
100 7 28

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) Russell Co. Ky.

13. NAME William C. Vandike

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

15. MAIDEN NAME Margaret E. Posey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

17. INFORMANT William Smith (ADDRESS) Callao, Mo. R. 1.

18. BURIAL, CREMATION, OR REMOVAL PLACE Worshipston Cem. DATE 7-3-1935

19. UNDERTAKER Stephens & Goodding (ADDRESS) _____

20. FILED 8/8 1935 Leota Newton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1-1935

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1934 to July 1, 1935
I last saw him alive on Dec 31, 1934 Death is said to have occurred on the date stated above, at 6:48 am.

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

Cardiac Weakness
Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? Phys 2 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 _____

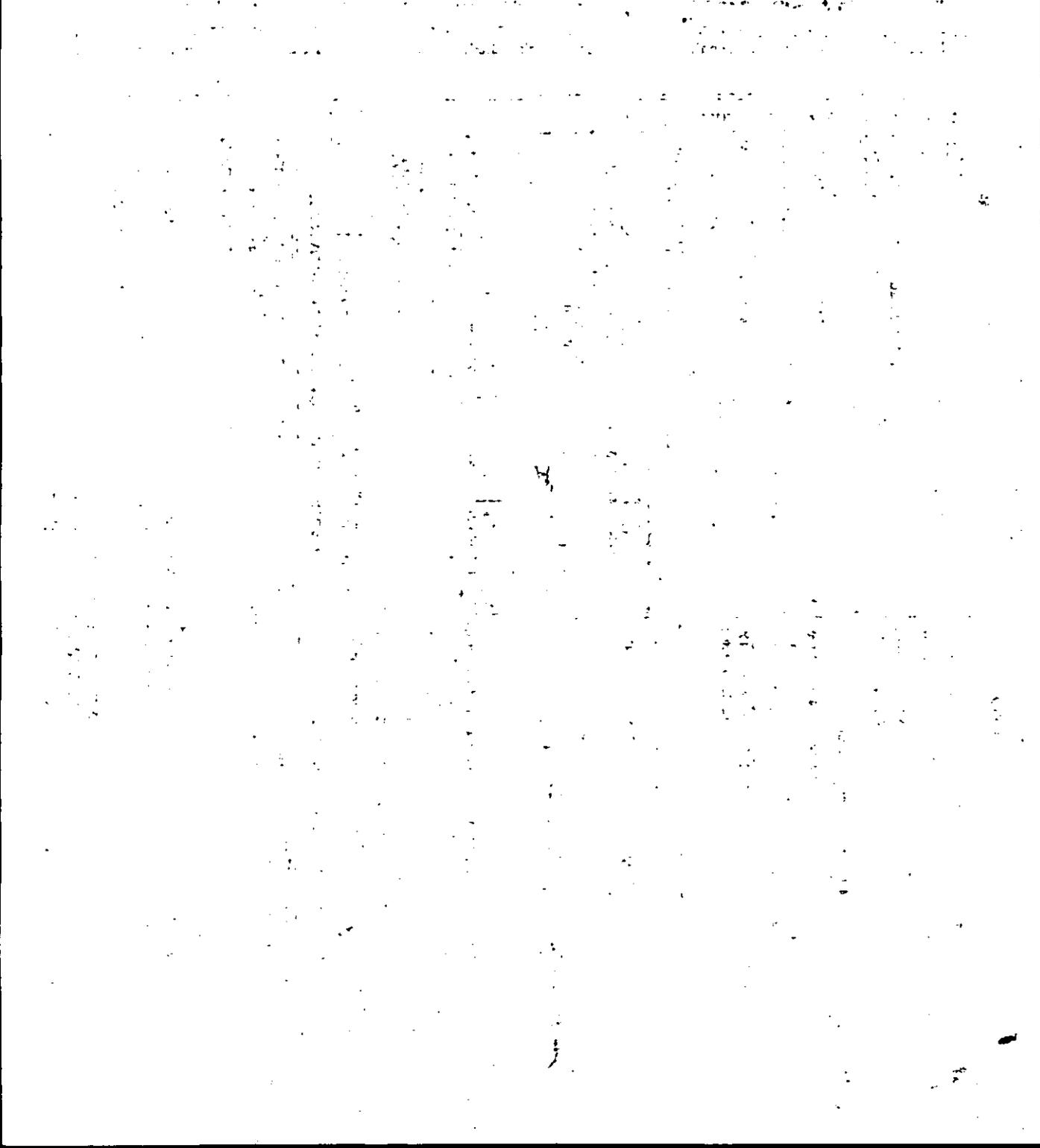
24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. A. Loh, M. D.(Address) Callao, Mo.

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.

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.

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 Macon
Township
City (No., St., Ward ..)

Registration District No. 533
Primary Registration District No. 2715-

File No.
Registered No. 188

2. FULL NAME

Martha Jane Smith

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

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

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

7. AGE YEARS MONTHS DAYS IS LESS than 1 day hrs. min.
100 7

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. UNDERTAKER (ADDRESS)

20. FILED 8/8 1935 Leola Newton Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1 1935

HEREBY CERTIFY, That I attended deceased from 19....., 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:
Cardiac Weakness
Chronic Myocarditis
Date of onset

Other contributory causes of importance:
980

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. J. Welch M. D.
(Address) Callio

SEP 2 1965

S-23675

EXHIBIT