

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

Do not use this space.

34869

1. PLACE OF DEATH *Nov 27 1935*
 100 County *Scott* Registration District No. *821*
 Township _____ Primary Registration District No. *4553*
 11 City *Sikeston, Mo* (No. _____) St. _____ Ward _____
 2. FULL NAME *Martha C. Ryan*
 (a) Residence, No. *Sikeston, Mo* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widow*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 13 - 1894*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 10 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*
 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 *Life*
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 FATHER 13. NAME *Unknown*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*
 MOTHER 15. MAIDEN NAME *Unknown*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*
 17. INFORMANT (ADDRESS) *Harley Ryan*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Memorial Park* DATE *Oct 18* 19*35*
 19. UNDERTAKER (ADDRESS) *John Althoff Sikeston, Mo*
 20. FILED *Oct 17* 19*35* *D. W. H. Powell* Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct - 16 1935*
 22. I HEREBY CERTIFY, That I attended deceased from *Oct 4* 19*35* to *Oct 16* 19*35*
 I last saw her alive on *Oct 16* 19*35*. Death is said to have occurred on the date stated above, at *11:30 P.M.*
 The principal cause of death and related causes of importance were as follows:
Pneumonia
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis *Chest* 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. H. Mayfield*, M. D.
 (Address) *Sikeston 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.

