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

20514

1. PLACE OF DEATH
County: St Francois — Registration District No.: 724 — File No.: 307
Township: St Francois — Primary Registration District No.: 4463 — Registered No.:
City: Elvins (No. ..... St. ..... Ward)

2. FULL NAME: Mary Anna Martin
(a) Residence. No. ..... St., ..... Ward. ..... (If nonresident give city or town and State)
(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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ~~Widow~~ Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3-4-51

7. AGE: Years 85 — Months 2 — Days 21 — If LESS than 1 day, ..... hrs. or ..... min.

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): own home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn

PARENTS
10. NAME OF FATHER: Arthur Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn

14. INFORMANT: W. S. Martin
(Address): Boss, Mo.

15. FILED 6-2, 1936 — C B Farrar MD, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 26th 1936

17. I HEREBY CERTIFY, That I attended deceased from May 14th, 1936, to May 26th, 1936, that I last saw her alive on May 26th, 1936, and that death occurred, on the date stated above, at 1:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY): Influenza
(duration) ..... yrs. ..... mos. 14 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? none
(Signed) Edgar E. Whiteside, M. D
, 19 (Address) Elvins 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Odd Fellow Bismarck (Cemetery) — DATE OF BURIAL: 5-27 1936

20. UNDERTAKER: Arthur Caldwell — ADDRESS: Flat River Mo.

MARGIN RESERVED FOR BINDING

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.

U. S. No. 2.

MISSOURI STATE BOARD OF HEALTH

# BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH.**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

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

**2. FULL NAME** .....

(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) |
|---|---|---|
| | | |

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. |
|---|---|---|---|---|
| | | | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED..... 19..... .....
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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