

JAN 25 1938

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

46861

Do not use this space.

## 1. PLACE OF DEATH

(a) County **Schuyler** Registration District No. **806**  
 (b) Township **Prarie** Primary Registration District No. **6031** Registered No. \_\_\_\_\_  
 (c) City **Near Queen City Mo.** (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. **4** mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Annie Martin**

(a) Residence, No. **Schuyler Co. Farm Residence** St. ☐ (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Wm. Martin (Deceased)**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 26th, 1868**  
 7. AGE YEARS **69** MONTHS **8** DAYS **18** IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **House Work**  
 9. Industry or business in which work was done, as saw mill, bank, etc. **Life**  
 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) **Near Lancaster Mo.** (STATE OR COUNTRY)

FATHER 13. NAME **David Creig**  
 14. BIRTHPLACE (CITY OR TOWN) **Not Known** (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Cowell first name not known**  
 16. BIRTHPLACE (CITY OR TOWN) **Not Known** (STATE OR COUNTRY)

17. INFORMANT **Mrs James Simmons** (ADDRESS) **Queenscity Mo.**18. BURIAL, CREMATION, OR REMOVAL **Thomas Cemetary** PLACE **Dec 16** DATE **37**19. FUNERAL DIRECTOR **William N. West** (ADDRESS) **Queenscity Mo.**20. FILED **12/15** **37** **J.T. Jones** Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec 14**, 19 **37**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 25**, 19 **37**, to time of death, 19 **37**.  
 I last saw him alive on **Nov 25**, 19 **37**. Death is said to have occurred on the date stated above, at **1030 A.M.**  
 The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 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 **Dr. C.H. and Del. Dr. M. D.**  
 (Signed) **Green Top Mrs.** (Address) \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I, William A West

Licensed Embalmer No. 2882

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Self.

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed

William A West

Licensed Embalmer No.

2882

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)