

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

Do not use this space.

1. PLACE OF DEATH:

94 County St. Francois
 4 Township St. Francois
 0 City Elmo (No. St. Ward)

Registration District No. 272
 Primary Registration District No. 4463

3943
 File No. 757
 Registered No.

2. FULL NAME Vera Calvin Martin 635

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Suzie Martin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 8th 1892

7. AGE YEARS 45 MONTHS 10. DAYS 20 If LESS than 1 day, hrs. or min.

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. laborer
 10. Date deceased last worked at this occupation (month and year) Jan 31 1938 Total time (years) spent in this occupation 20

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Went Co Mo

FATHER 13. NAME John Calvin Martin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Went Co Mo

MOTHER 15. MAIDEN NAME Urene Kitchens

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Went Co Mo

17. INFORMANT Suzie Martin
 (ADDRESS) Elmo Mo

18. BURIAL, CREMATION, OR REMOVAL Went Co Mo
 PLACE Went Co Mo DATE 1-30-38

19. UNDERTAKER Baldwin Bros
 (ADDRESS) Went Co Mo

20. FILED 2/2 1939 B. H. Carran
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28, 1938

22. I HEREBY CERTIFY that I attended deceased from Dec 10, 1937, to Jan 28, 1938

I last saw him alive on Jan 27, 1938. Death is said to have occurred on the date stated above, at 4 p.m.

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

menie's cancer
Chronic nephritis & hypertension
 Other contributory causes of importance:
Hypertension
Menie's Depressive

Name of operation none Date of operation

What test confirmed diagnosis? Exam Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?

Where did injury occur?

Manner of injury

24. Was disease or injury in any way related to occupation of deceased? NO
 If so, specify

(Signed) C. H. Appleberry, M. D.
 (Address) Went Co Mo

132a

RECEIVED

FEB 28 1938

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3943
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 772
(b) Township _____ Primary Registration District No. 4463 Registered No. _____
(c) City Elvins (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. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mr. Calvin Martin

(a) Residence, No. _____ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
45 10 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28, 1938

22. I 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:

urinary coma
chronic nephritis
hypertension

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 _____
(Signed) C. H. Appleberry, M. D.
(Address) 124th Avenue, New

1938
S-3943