

REC'D SEP 12 1939

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

File 29151  
Do not use this space.

1. PLACE OF DEATH  
 (a) County GREENE Registration District No. 318  
 (b) Township \_\_\_\_\_ Primary Registration District No. 21001  
 (c) City SPRINGFIELD (d) Street No. 429 W. Page 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.  
 2. PRINT FULL NAME Wayne Martin  
 (a) Residence, No. 429 W. Page 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 W. A. Martin  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 28, 1855  
 7. AGE YEARS 83 MONTHS 4 DAYS 15 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Homemaker  
 9. Industry or business in which work was done, as saw mill, bank, etc. Home  
 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) Murphyport Ark.  
 FATHER 13. NAME Reed Davis  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Troy Tenn.  
 MOTHER 15. MAIDEN NAME Elizabeth Smith  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.  
 17. INFORMANT (ADDRESS) Mrs. H. J. Johnson 429 W. Page Springfield Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE East Lawn Ceme DATE 8-15 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Johnson 21001 Springfield Mo.  
 20. FILED Aug 15 1939 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 13 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 10-2-37 to 8-13-39, 1939  
 I last saw her alive on July 28, 1939 Death is said to have occurred on the date stated above, at 4:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Valvular heart lesion Date of onset years  
9 1/2  
 Other contributory causes of importance Gen Senility  
 Name of operation None Date of .....  
 What test confirmed diagnosis? Chemical Was there an autopsy? Yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? None Date of injury no, 19.....  
 Where did injury occur? None (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury None  
 Nature of injury None  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify .....  
 (Signed) L. J. Johnson M. D.  
 A (Address) Springfield

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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**

X