REC'D SEP 14 1939

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

29851
Do not use this space.

76

1. PLACE OF DEATH
(a) County OSAGE Registration District No. 643
(b) Township JEFFERSON Primary Registration District No. 5852 Registered No.
(c) City (NEAR) COOPER HILL (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 453 MARTHA MARGARET VALENTINE
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
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 HERMAN VALENTINE

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN 16 1876

7. AGE: Years 64 Months 4 Days 17 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE
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) NEW WOOLLAM MO.

FATHER
13. NAME FRITZ WEIGMANN
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

MOTHER
15. MAIDEN NAME DORA BAYDER
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

17. INFORMANT MRS. Guy Kramer (ADDRESS) Cooper Hill

18. BURIAL, CREMATION, OR REMOVAL M.E. CEMETERY
PLACE NEW WOOLLAM DATE 6-15 1939

19. FUNERAL DIRECTOR W. F. Gattenbarter (ADDRESS) Owensville Mo.

20. FILED Sept 11 1939 Mrs Linnie Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 13 1939

22. I HEREBY CERTIFY, That I attended deceased from June 9 1939 to June 13 1939
I last saw her alive on June 13 1939 Death is said to have occurred on the date stated above, at 5:25 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrage — 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) Dr. Charles T. Leach, M. D.
(Address) Bland Mo #3

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Mifford N N Winter, Licensed Embalmer No. 3838

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

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed Mifford N N Winter

Licensed Embalmer No. 3838

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH
(a) County Osage — Registration District No. 643
(b) Township Jefferson — Primary Registration District No. 3852 — Registered No.
(c) City — (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 Martha Margaret Valentine
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1-16-1876
7. AGE: YEARS 63 — MONTHS 4 — DAYS 17 — If LESS than 1 day, ...hrs. or ....min.

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 Nov 8 1939 Lenora Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6 - 13, 1939
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:

	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) Chas T. Leach, M. D.
(Address) Blend Mo R F R 3

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.