

SEP 15 1939

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

30356
Do not use this space.

1. PLACE OF DEATH
 (a) County Shannon Registration District No. 824
 (b) Township Emmace Primary Registration District No. 6076 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 Ola 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 F 4. COLOR OR RACE A 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rat Martin
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Data 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) Mo
 FATHER 13. NAME S
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) S
 MOTHER 15. MAIDEN NAME S
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) S
 17. INFORMANT (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE Donnell Cemetery DATE 8-2- 39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) None
 20. FILED 8-2- 1939 Frank J. Taylor M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug-2- 1939
 22. I HEREBY CERTIFY, That I attended deceased from Jan-1- 1937 to Aug-2- 1939.
 I last saw him alive on May 1, 1939. Death is said to have occurred on the date stated above, at 6:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis
 Date of onset 73'
 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
 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) Frank J. Taylor M. D.
 (Address) Emmace Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTODUPLICATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

RECEIVED
working under my personal supervision.

District Health Officer No. 5,

District File Number 936 206

Date Filed 9/11/39

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30356

Do not use this space.

1. PLACE OF DEATH
 (a) County Shannon Registration District No. 824
 (b) Township Minience Primary Registration District No. 6076
 (c) City..... (d) Street No..... Registered No.....
 (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 Ola Martin
 (a) Residence, No. St. (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) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rol Martin

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>45</u>			

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) Mo

FATHER
 13. NAME Garry McMillan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Tom Martin
 (ADDRESS) Sumner Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE..... DATE..... 19.....

19. FUNERAL DIRECTOR
 (ADDRESS).....

20. FILED 8-8- 1939 Frank Boyd MD
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-7 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) Frank Hyde, M. D.
 (Address) Sumner Mo

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

Exact statement of OCCUPATION is very important. Do not omit any property classed. Exact statement of OCCUPATION is very important.

S-30356