

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

21364
Do not use this space.

FILED JUL 15 1940

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 171
 (c) City Fulton (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 Ms. Martha J. Murray

(a) Residence, No. _____ (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 Female **4. COLOR OR RACE** Negro **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word)** Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1872

7. AGE YEARS 68 MONTHS _____ DAYS _____ **IF LESS than 1 day, _____ hrs. or _____ min.**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

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** 121

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME William Johnson

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

15. MAIDEN NAME Kizzie Cason

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

17. INFORMANT (ADDRESS) Mrs. Berneice C. Hill
218 N. 9th - Fulton, Mo

18. BURIAL, CREMATION, OR REMOVAL At Fulton, Mo DATE July 3, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edw. Bell
Fulton, Mo

20. FILED July 3, 1940 R. N. Crews
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29 - 1940

22. I HEREBY CERTIFY, that I attended deceased from 12:15, 1939, to 6:29, 1940
 I last saw her alive on 6/29, 1940 Death is said to have occurred on the date stated above, at 9 P. m.
 The principal cause of death and related causes of importance were as follows:
chr. myocarditis
chr. nephritis

Date of onset Dec. 1939

Other contributory causes of importance: _____

Name of operation none **Date of** _____
What test confirmed diagnosis? clinical **Was there an autopsy?** no

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? no
 If so, specify _____
 (Signed) Henry Dent, M. D.
 (Address) 101 1/2 610 Cont., Fulton, Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

social security no. - none

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..... *Eli Bell*

Licensed Embalmer No. *2130*

P. O. Address *Fulton Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21364
Registrar's No. 171

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 104

Primary Registration District No. 3008

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Callaway
(c) City or town Fulton
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME

Mrs Martha J Murray

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race white

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years 68

Months #

Days #

If less than one day _____ h. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 1, 1940 (b) _____

(Date received local registrar)

R. N. Crews

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions Cholera septicemia
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Henry Dues (M.D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL REPORT

