DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 5 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15495

Registration District No. 279 Primary Registration District No. 5957 Registrar's No. 6

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Eolia Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether)
In this community 35 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Eolia
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nancy Ellen Martin
3. (b) If veteran, name war no.
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
deceased
7. Birth date of deceased May (Month) 8 (Day) 1849 (Year)

8. AGE: Years	Months	Days	If less than one day
94	11	0	hr. min.

9. Birthplace Pike Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name [illegible]
FATHER 13. Birthplace [illegible] (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Martha Richardson
MOTHER 15. Birthplace Ill (City, town, or county) (State or foreign country)
16. (a) Informant Gertrude Millinor
(b) Address Detroit Michigan
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Alexander Cemetery
18. (a) Signature of funeral director Gooch Hdw Co
(b) Address Eolia Mo
19. (a) Apr 8th (Date received local registrar) (b) B. M Gooch Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 7th year 1944 hour 1 minute 45 P.M.
21. I hereby certify that I attended the deceased from Jan. 11 1944, to April 7 1944, that I last saw her alive on April 7 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cancer of Stomach	6 moo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Dr. D.G. Hazzard (M. D. or other) M.D.
Address Eolia, Mo. Date signed 4-10-44.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 10
District File Number 5-44-906
Date Filed MAY 8 1944

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
43
K36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May 6

Registration District No. 279 Primary Registration District No. 5957 Registrar's No.

1. PLACE OF DEATH:
(a) County Pike Prairieville Twp
(b) City or town (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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nancy Ellen Martin
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 8 (Day) 1849 (Year)

8. AGE: Years 94 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business Retired

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) April 14th (Date received local registrar) (b) Maude M. Patton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

15495