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.

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

PLACE OF DEATH

County DeKalb

Township Adams or Village or City

Registration District No. 263 — File No. 19 34691

Primary Registration District No. 5-365 — Registered No. 99

(No. ____ St. ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Martha Ann Estep

PERSONAL AND STATISTICAL PARTICULARS

~~SEX~~	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
female	white	Yes

DATE OF BIRTH April (Month) 6 (Day) 1851 (Year)

AGE 66 yrs. 6 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS

NAME OF FATHER Newton Matheny

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.

MAIDEN NAME OF MOTHER Minerva Hildebrand

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Estep

(ADDRESS) Maysville Mo.

Filed Oct 20. 1917. J. F. Hedrick, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October (Month) 11 (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July, 1917, to October 11, 1917, that I last saw her alive on Oct 10 —, 1917, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach
46B

(Duration) 10 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. F. Clark M. D.

Oct 12. 1917 (Address) Maysville Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Redman Cemetery — DATE OF BURIAL Oct 13 1917

UNDERTAKER J. L. Davis — ADDRESS Maysville

PLACE OF DEATH

County _____

Township _____ or
Village _____ or
City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occu
hospital or in
give its NAM
of street and nu

Revised United States Standard Certificate of Death

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____,
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased
_____, 191__, to _____, 1
that I last saw h____ alive on _____, 1
and that death occurred, on the date stated above, at ____
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) ____ yrs. ____ mos. ____

Contributory _____
(SECONDARY)
_____ (Duration) ____ yrs. ____ mos. ____

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____,
UNDERTAKER	ADDRESS

"Typhoid pneumonia"; *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);