

OCT 26 1927

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

Do not use this space.

27122

1. PLACE OF DEATH

County Jackson

Registration District No. 398

Township Blue

Primary Registration District No. 5554

City Wentzville (No. RFD # 6)

File No.

Registered No. 254

St. Ward)

2. FULL NAME

Martha N Dallas

(a) Residence. No. 1546 Poplar St.,

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Roland Dallas

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

9-10-1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. min.

66

11

18

8. OCCUPATION OF DECEASED

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

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Bostain Vance

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

don't know

12. MAIDEN NAME OF MOTHER

Mary Blouse

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Pennsylvania

14.

INFORMANT (Address)

Mrs Ella Halsey
223 N. Cedar

15.

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Sept 28 1927

17.

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1927, to Sept 28, 1927, that I last saw him alive on Sept 28, 1927, and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Failure
Resulting from
Bronchopneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

Myocarditis Chronic

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED THE DIAGNOSIS?

(Signed) Wheeler, M. D.

Address Sept 29 1927 Fairmount Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Shell City Mo

Sep 30 1927

20. UNDERTAKER

ADDRESS

O. H. Mitchell Indeb Mo.

N. B.—Every item of information 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.

STATE OF CALIFORNIA
COUNTY OF ...
IN SENATE
JANUARY 11, 1961
SENATOR ...
STATE OF CALIFORNIA
COUNTY OF ...
IN SENATE
JANUARY 11, 1961
SENATOR ...

13

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Blue
City Martha N. Dallas

Registration District No. 398
Primary Registration District No. 3337

File No. 254
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Martha N. Dallas

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-10-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
67 | 0 | 18

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

14.

INFORMANT _____
(Address)

15.

FILED Nov 10 1927 F. L. LOCKY
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) yrs. mos. da.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

19

20. UNDERTAKER _____ ADDRESS _____

N. B.—Every item on this certificate should be carefully examined and EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

