JUN 24 1930

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

Do not use this space.

15231

1. PLACE OF DEATH
County Atchison
Township Clay
City Rock Port (No. ..... St. ..... Ward)
Registration District No. 19
Primary Registration District No. 4818
File No.
Registered No.

2. FULL NAME Martha J. Slater
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

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

7. AGE: Years 64 | Months 3 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

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): Iowa

PARENTS
10. NAME OF FATHER: Mitchell Dalrymple
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Jane McCoy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Penn.

14. INFORMANT: Jas. Slater
(Address): Rock Port Mo

15. FILED 5-30, 19..... Mary J. Chamberlain, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-30 1930

17. I HEREBY CERTIFY, That I attended deceased from May-23, 1930, to May-30, 1930, that I last saw her alive on May-30, 1930, and that death occurred, on the date stated above, at 5 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pneumonia Lobar
108
(duration) - yrs. - mos. 7 ds.

CONTRIBUTORY (SECONDARY): Feble Constitution
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At Residence
DID AN OPERATION PRECEDE DEATH? No. DATE OF -
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? No Special
(Signed) Austin McMichael, M. D
5-30, 1930 (Address) Rock Port 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: Greenhill Cem.
DATE OF BURIAL: 6-1 1930

20. UNDERTAKER: Gratz Bartholomew
ADDRESS: Rock Port Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Atchison — Registration District No. 19 — File No. .....

Township ..... — Primary Registration District No. 4018 — Registered No. .....

City Rock Park (No. ..... St. ..... Ward)

2. FULL NAME Martha T. Slater

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) Feb 9 - 1866

7. AGE: 64 YEARS — MONTHS: 3 — DAYS: 21 — If LESS than 1 day, ... hrs. or ..... min.

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 5-30, 1930. Mary J. Chamberlain REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., 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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

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.

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

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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

...information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...TH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

9-15931