

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

18202
 Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 143
 (c) City Fulton (d) Street No. State Hospital # 7 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 361 Marth 2 Weatherford St.
Bowling Green, Mo
 (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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
76

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. Home
 10. Date deceased last worked at this occupation (month and year) D.K. 11. Total time (years) spent in this occupation. Life

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

FATHER 13. NAME William Martin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

MOTHER 15. MAIDEN NAME Sara Lane

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K.

17. INFORMANT (ADDRESS) Hoop Records

18. BURIAL, CREMATION, OR REMOVAL Bowling Green, Mo. 55 28 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. Beukel
Bowling Green Mo

20. FILED May 27 1939 R. N. Cross
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 26 1939

22. I HEREBY CERTIFY That I attended deceased from April 21 1939 to May 26 1939
 I last saw her alive on May 26 1939 Death is said to have occurred on the date stated above, at 3:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Generalized Arteriosclerosis indif.
Bronchopneumonia

Other contributory causes of importance: 107K
stroke

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....
 If so, specify M. Wood M. D.
 (Signed) M. Wood
 (Address) State Hosp # 7 Fulton Mo

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. *2284*

P. O. Address *Baltimore Green MD*

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.