

JAN 14 1940

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

5748
Do not use this space.

1. PLACE OF DEATH

(a) County Waver Registration District No. 2
(b) Township 2 Primary Registration District No. 4004 Registered No. 26
(c) City Aswinger (d) Street No. _____ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MARTHA ELLEN DAYTON
(a) Residence, No. Novinger 1 mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|------------------------------|--|
| 3. SEX <u>Female</u> | 4. COLOR OR RACE <u>W</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widowed</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sam Dayton</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct. 14 1835</u> | | |
| 7. AGE <u>104</u> | YEARS <u>2</u> | MONTHS <u>26</u> |
| 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. | | |
| 9. Industry or business in which work was done, as saw mill, bank, etc. | | |
| 10. Date deceased last worked at this occupation (month and year) | | 11. Total time (years) spent in this occupation |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana 1</u> | | |
| 13. NAME <u>John Strikons</u> | | |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana 1</u> | | |
| 15. MAIDEN NAME <u>(don't know)</u> | | |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana 1</u> | | |
| 17. INFORMANT (ADDRESS) <u>Rensford Dayton</u> | | |
| 18. BURIAL, CREMATION, OR-REMOVAL PLACE <u>Bear Creek</u> DATE <u>Jan 11 1940</u> | | |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Kirkville Mo Summers Funeral Home Spencer Freeman Local Registrar</u> | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 7 1940

22. I HEREBY CERTIFY That I attended deceased from Jan 4 1940 to Jan 9 1940
I last saw her alive on Jan 9 1940 Death is said to have occurred on the date stated above, at 9:00 m.
The principal cause of death and related causes of importance were as follows:
Pneumonia Date of onset Jan 4 1940

Other contributory causes of importance:
107W

Name of operation None 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? X 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 _____
(Signed) A. J. Garrison M.D. (Address) Novinger Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM-1-12-38
V. S. NO. 2.
I X14028

RECEIVED

District Health Officer No. 10

District File Number 3-40-589

Date Filed MAR 12 1940

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5748**
Registrar's No. **26**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **2** Primary Registration District No. **4004**

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

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Nowinger**
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Martha Ellen Payton**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **fe** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
104 2 26 hr min

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

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) **4-2-1990** (Date received local registrar) (b) **Spencer L. Freeman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Adair**
(c) City or town **Nowinger** (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month **1** day **7** year **1990** 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.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature **H. P. Garrison** (M. D. or other)

Address **Nowinger mo** Date signed.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-5748