

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7918

Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 744
 (b) Township Hennrette Primary Registration District No. 5926B Registered No. 278-17
 (c) City Hennrette Mo. (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 Mary Elizabeth Martin

(a) Residence, No. Hennrette Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1st, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House keeper
 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) Missouri (STATE OR COUNTRY)

FATHER 13. NAME Charles Calloway

14. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Rebecca Calloway

16. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)

17. INFORMANT Maggie Cot (ADDRESS) Hennrette Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hickory Grove DATE Feb. 16 th, 1940

19. FUNERAL DIRECTOR (NAME) Brothers Funeral Home (ADDRESS) Richmond Mo.

20. FILED Feb. 20 1940 Malcol Jackson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1940, to Feb 14, 1940

I last saw her alive on Feb 12, 1940. Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:

Chronic Interstitial nephritis Date of onset

Other contributory causes of importance: 121

Advanced Arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

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? no
 If so, specify GW Staines M. D.
 (Signed) Richmond, Mo.
 (Address) Richmond, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

I X16603

Date Filed
Licence File Number
District Health Officer No. 8

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
J.E. Brothers, Registered Apprentice No. 2001

working under my personal supervision.

Brothers Funeral Home

Signed
Licensed Embalmer No. 2001
P. O. Address Richmond Mo.

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. **7918**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **744**

Primary Registration District No. **297613**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Ray**
(b) City or town **Richmond Rural**
(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..... (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Ray**
(c) City or town **Henrietta Mo**
(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

3. (a) **PRIN FULL NAME** **Mary Elizabeth Merten**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **7** 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..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **81** Months **13** Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) **Feb 20-40** (b) **Malcolm Jackson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **14** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that the deceased was 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 **G.W. Gandy** (M. D. or other)
Address **Richmond** (City or town)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

