JUN 25 1929

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

Do not use this space.

17615

1. PLACE OF DEATH
County Clay
Registration District No. 201
File No.
Township Liberty
Primary Registration District No. 3012
Registered No. 44
City (No. St. Ward)

2. FULL NAME Martha Capps

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 8-1868

7. AGE: YEARS 60 MONTHS 11 DAYS 23 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) Liberty (STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Geo. Young
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Clay Co Mo
12. MAIDEN NAME OF MOTHER Malinda Tyree
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) N.C.

14. INFORMANT Vassie Willis
(Address) Liberty Mo

15. FILED 6/10/29 Wm H Goodson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to ....., 19...
that I last saw h... alive on May 1, 1929, and that death occurred, on the date stated above, at 1 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypostatic pneumonia
O.B
118
(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (SECONDARY) Cerebral Haemorrhage
(duration) ....yrs. 3 mos. ....ds.

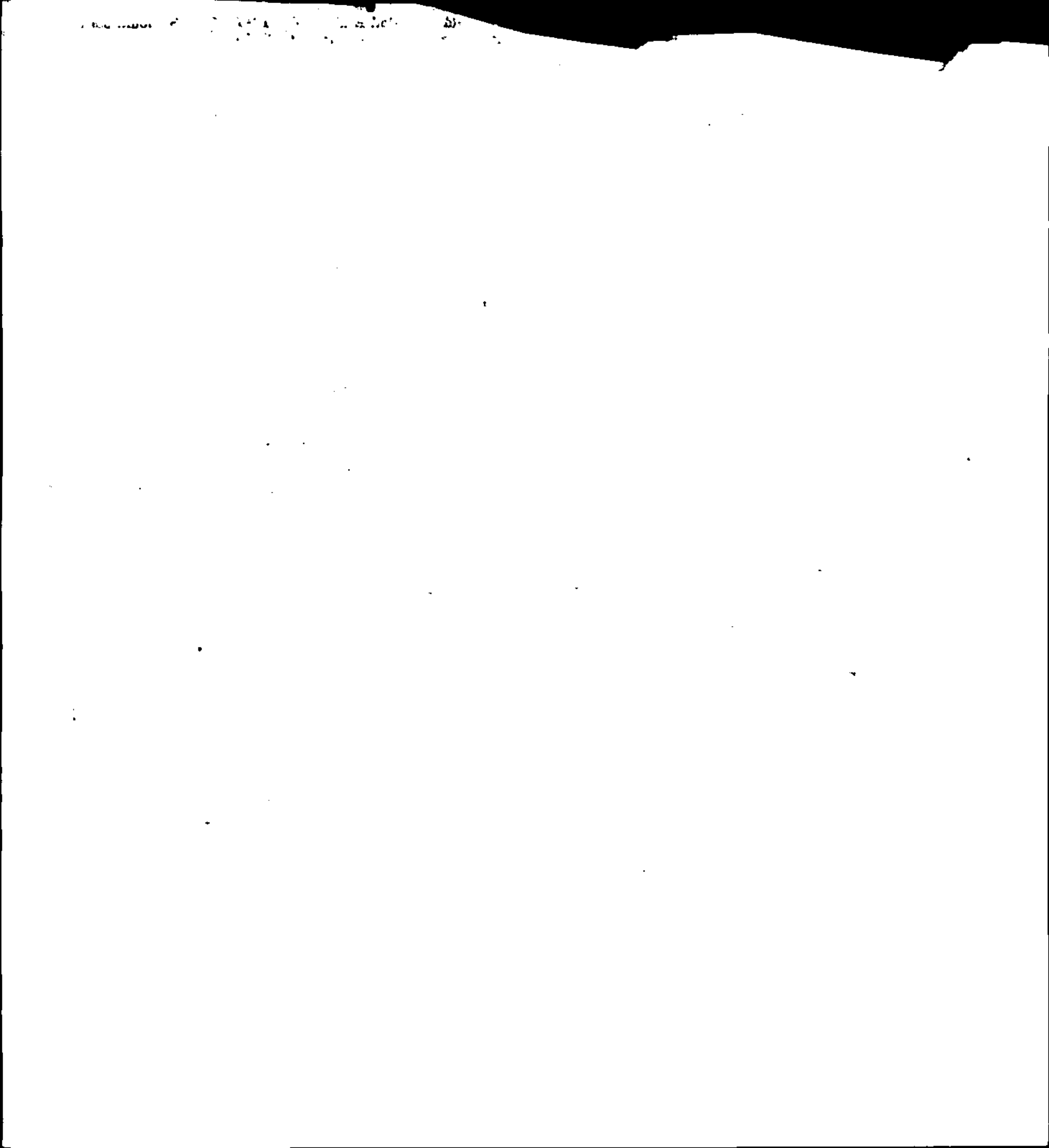
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Wm H Goodson, M. D.
5/4/29, 19 (Address) Liberty Mo.

*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 Fairview Liberty Mo
DATE OF BURIAL 5/3/1929

20. UNDERTAKER Church-Archer Co
ADDRESS Liberty Mo

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.



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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

17615

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Registered No. 44
City Liberty (No. St. Ward)

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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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Col	Wid

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

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

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

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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 8/10/29 Wm H Gordon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm H Goodson, M. D.

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

103

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.

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

5-17615