

FILED MAR 13 1943

Registration District No. 3057

Primary Registration District No. 3057

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond mo.  
(c) Name of hospital or institution: Home Health College  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 62 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Martha Sophia Daugherty  
3. (b) If veteran, name war no 3. (c) Social Security No. no

6. (a) Name of husband or wife Christine C. Daugherty 6. (b) Color of hair white 6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased March 8-8-1869  
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Andrew Madsen

12. Name Don't know

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Max Taster

(b) Address Richmond Mo

17. (a) Burial (b) Date thereof 3-1-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond Cemetery

18. (a) Signature of funeral director R. R. Bagger

(b) Address Madison Mo.

19. (a) MAR 1 43 (b) Muchowski Shipp  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Ray  
(c) City or town Richmond mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 28 Year 1943 hour 3 minute 2 M.

21. I hereby certify that I attended the deceased from Feb 7 to Feb 28, 1943  
that I last saw her alive on Feb 28, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Arterio-Sclerosis

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 E. E. Bag (M. D. or other) \_\_\_\_\_

Address Richmond Mo Date signed 3-1-43

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-12-43

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

*R. W. Boggs*

Licensed Embalmer No.

3576

P. O. Address

*Ridgeway 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, fact should be so stated above.

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. 7389  
12  
 Registrar's No. ....

Registration District No. 297

Primary Registration District No. 3057

1. PLACE OF DEATH:

(a) County Ray  
 (b) City or town Richmond  
 (If outside city or town limits, write "RURAL" and name of township)  
 (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)

3. (a) PRINT FULL NAME Martha Sophia Daugherty

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 8 18 (Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 10 If less than one day \_\_\_\_\_ min.

9. Birthplace Denmark (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary neumonia Duration \_\_\_\_\_

Due to bronchial

Due to \_\_\_\_\_

Other conditions arteriosclerosis (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 107

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 E. B. Lay (M. D. or other) \_\_\_\_\_

Address Richmond Date signed \_\_\_\_\_

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

1994-1995

1996-1997

1998-1999

2000-2001

2002-2003

2004-2005

2006-2007

2008-2009

2010-2011

2012-2013

2014-2015

2016-2017

2018-2019

2020-2021

2022-2023

2024-2025

2026-2027

2028-2029

2030-2031

2032-2033

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2096-2097

2098-2099

2100-2101

2102-2103

2104-2105

2106-2107

2108-2109

2110-2111

2112-2113

2114-2115

2116-2117

2118-2119

2120-2121

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2160-2161

2162-2163

2164-2165

2166-2167

2168-2169

2170-2171

2172-2173

2174-2175

2176-2177

2178-2179

2180-2181

2182-2183

2184-2185

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2198-2199

2200-2201

2202-2203

2204-2205

2206-2207

2208-2209

2210-2211

2212-2213

2214-2215

2216-2217

2218-2219

2220-2221

2222-2223

2224-2225

2226-2227

2228-2229

2230-2231

2232-2233

2234-2235

2236-2237

2238-2239

2240-2241

2242-2243

2244-2245

2246-2247

2248-2249

2250-2251

2252-2253

2254-2255

2256-2257

2258-2259

2260-2261

2262-2263

2264-2265

2266-2267

2268-2269

2270-2271

2272-2273

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