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

Do not use this space. 40424 ~~17~~ S

1. PLACE OF DEATH

County: ..... Registration District No. 791

Township: ..... Primary Registration District No. 1003

City: St Louis (No. 4507 McPherson St. ..... Ward)

File No. ..... Registered No. U 24

2. FULL NAME Reuben T. Martin

(a) Residence. No. 4507 McPherson St., 12 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: Male

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: Augusta B. Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 19, 1843

7. AGE: Years 83 | Months 9 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Robert T. Martin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia

12. MAIDEN NAME OF MOTHER: Susan Ladinn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia

14. INFORMANT: Lillie M. Warner (Address) Dayton Ohio

15. FILED: JAN -3 1927 Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 31 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1926, to Dec 31st, 1926, that I last saw h..... alive on Dec 31, 1926, and that death occurred, on the date stated above, at 5:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Cystitis

135B

162

133B

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Incontinence

..... (duration) ..... yrs. ..... 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) [signature], M. D

Dec 31, 1926 (Address) Grand Ohio

*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: St Matthews

DATE OF BURIAL: Jan 2 1927

20. UNDERTAKER: Wagner

ADDRESS: 3621 Olive

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.