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

Do not use this space.

10268

APR 24 1929

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township — Primary Registration District No. 2001
City Springfield (No. 1935 N. Grant St. Ward)

File No.
Registered No. 207

2. FULL NAME Benjamin L. Martin
(a) Residence. No. 1935 N. Grant 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.

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.

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~~ Anna Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 25 - 1868

7. AGE: Years 60 | Months 11 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Justice of Peace
(b) General nature of industry, business, or establishment in which employed (or employer): N. Campbell Twp
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): N. Carolina

PARENTS
10. NAME OF FATHER: Wm Martin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): N. Car.
12. MAIDEN NAME OF MOTHER: Catherine Little
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs. Anna Martin
(Address) Springfield, Mo.

15. FILED 3/6 29 — O C Horst MD — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1.

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/5 1929

17. I HEREBY CERTIFY, That I attended deceased from 3/5, 1929, to 3/5, 1929 that I last saw him alive on 3/5/29, 19..., and that death occurred, on the date stated above, at 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Apoplexy
(duration) ..... yrs. ..... mos. 8 hrs

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? N/A

(1) DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S F Freeman, M. D
3/6, 1929 (Address) Springfield 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: Green Lawn Cemetery — DATE OF BURIAL: 3/7 1929

20. UNDERTAKER: J. W. Klingner & Co. 424 Conil St Springfield, Mo. — ADDRESS

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