

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

20052

Do not use this space.

REC'D JUN 24 1939

1. PLACE OF DEATH

(a) County Verdon Registration District No. 875
 (b) Township Washington Primary Registration District No. 6162 Registered No. 133
 (c) City Neveaded or State Hospital #3 St. St.
 (d) Street No. State Hospital #3 (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 0 yrs. 4 mos. 3 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

635 Claude Gayleid Martin
 (a) Residence, No. State Hospital #3 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 22, 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>57</u>	<u>6</u>	<u>0</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Physician
 9. Industry or business in which work was done, as saw mill, bank, etc. Medicine
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Records, State Hospital #3
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL Fairview
 PLACE May 23 DATE 1939

19. FUNERAL DIRECTOR (NAME) Louise Mott
 (ADDRESS) Gopher Mo

20. FILED 5/22 1939 Accur V. Hays
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1938, to May 22, 1939
 I last saw him alive on May 13, 1939. Death is said to have occurred on the date stated above, at 542 m.

The principal cause of death and related causes of importance were as follows:

Coronary Heart Disease Date of onset _____
946
 Other contributory causes of importance:
Maniacal Exhaustion

Name of operation _____ Date of _____
 What test confirmed diagnosis? None 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 _____
 (Signed) Russ H. Patten, M. D.

(Address) State Hosp #3, Nevada

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 X16605

RECEIVED

District Health Officer No. 7

District File Number 7-39-88

Date Filed 6-6-39

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.....

F. M. Jones

Licensed Embalmer No. 2319

P. O. Address.....

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.