

Registration District No. 701

Primary Registration District No. 1000

Registrar's No.

1. PLACE OF DEATH:

(a) County 1
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Desloge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Year
(Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town Ferguson NR
(If outside city or town limits, write "RURAL")
(d) Street No. 305 Randolph Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William J. Martin 635

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Maddocks Martin 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased Aug 25 1904
(Month) (Day) (Year)

8. AGE: Years 35 Months 2 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace St Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer Dept

11. Industry or business _____

12. Name William M Martin

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name May Layton
(City, town, or county) (State or foreign country)

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address 3910 Lincoln Ave

17. (a) Burial (b) Date thereof 11/15/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) NOV 13 1939 (b) J. J. [Signature]
(Date received local health officer's signature) (Health officer's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1939 hour 11 minute 25a M.

21. I hereby certify that I attended the deceased from 7-10-39 to Nov 11 1939
that I last saw him alive on 11/11/39
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure

Due to Leukemia
myelogenous

Due to _____

Other conditions (Include pregnancy within 6 months of death) _____

Major findings: Of operation _____

Of autopsy Confirmed diagnosis

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Romether (M. D. or other) _____

Address 3720 Washington Date signed 11/13/39

I X1051
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.

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 Frank H. Howard

Licensed Embalmer No. 2265

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.