

JAN 12 1940

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41744

Registrar's No. 10867

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

- (a) County 1003 /
- (b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution 12 days
(Specify whether _____)
- In this community Unknown
years, months or days

8. (a) PRINT FULL NAME William Martin 6353. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mr Irene Martin 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased January 4 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 11 13 hr. _____ min.9. Birthplace Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Electrician 6

11. Industry or business _____

- MOTHER FATHER
12. Name Wm H. Martino
13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Carnie Boyd
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Irene Martin(b) Address 3510 Eozens St.17. (a) Burial (b) Date thereof 12-20-39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Green Wood18. (a) Signature of funeral director E. E. Garner(b) Address 2829 Washington Ave19. (a) DEC 20 1939 (b) J. B. Baddish
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
- (c) City or town St Louis 21
(If outside city or town limits, write "RURAL")
- (d) Street No. 3510 a Eozens
(If rural, give location)
- (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 17 day 17 1939
year 1939 hour 12:25 minute 25 A. M.21. I hereby certify that I attended the deceased from
December 6, 1939, to December 17, 1939;
that I last saw h. im alive on December 17, 1939;
and that death occurred on the date and hour stated above.Immediate cause of death _____ Duration
Hypertensive Heart Disease 5-6 years
Diabetes Mellitus 1-3 yrs

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 9 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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 H. J. Lyman (M. D. or other) _____
Address 2601 N Whittier Date signed _____

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 Arthur S. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

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.