

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18187

State File No. _____

Registration District No. 148

Primary Registration District No. 3011

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
617 Old Orchard Ex. Spgs Mo.
(If not in hospital or institution, write street number and occupation)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 63 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 617 Old Orchard Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME YOUNG EBEN MARTIN

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

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

6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive > years

7. Birth date of deceased March 16 - 1877
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|--------|-----------|----------------------|
| | <u>63</u> | | <u>16</u> | hr. _____ min. _____ |

9. Birthplace Excelsior Springs Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation grocery

11. Industry or business _____

12. Name Calvin C. Martin

13. Birthplace Excelsior Springs Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Sims

15. Birthplace May Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ruthann Crockett
(b) Address Excelsior Springs Mo.

17. (a) Salem (burial) (b) Date thereof May 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem

18. (a) Signature of funeral director Herbert Hope
(b) Address Excelsior Springs Mo.

19. (a) May 4, 1940 (b) Mrs. Wm. M. Crockett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1940 hour 2:30 minute P M.

21. I hereby certify that I attended the deceased from May 1
1940 to May 30, 1940
that I last saw him alive on May 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 10 PM. 16 hrs
May 1 - 1940

Due to _____
Due to _____

Other conditions General arteriosclerosis
(Include weakness within months of death)
stroke 18 months ago

Major findings: _____
Of operations _____
Of autopsy no

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) no

(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?
180
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. D. Craven (M. D. or other) _____
Address Excelsior Springs Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number
6-4-40

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 *W. H. Kern*
Licensed Embalmer No. 3597
P. O. Address Excelsior Springs, Mo.

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.