

No. 2
1-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32436**

Registration District No. **475**

Primary Registration District No. **5639**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Lawrence**
(b) City or town **Rural (Springriver Twnship)**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Thomas F Martin**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Eula Martin** 6. (c) Age of husband or wife if alive **40** years
7. Birth date of deceased **Sept 21**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 **0** **2** hr. min.

9. Birthplace **? Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **unknown**

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

14. Maiden name _____
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Arnold B. Martin**
(b) Address **Verona Mo.**

17. (a) **Burial** (b) Date thereof **9/25/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Verona Mo.**

18. (a) Signature of funeral director **J. F. King** **426**
(b) Address **Aurora Mo.**

19. (a) **9/25/40** (b) **A. King**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Lawrence**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. # 1 Verona Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **23**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **after death**, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart attack**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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)
Means of injury _____

23. Signature **Herman Duridge** (M.D. or other) **5**
Address **Aurora Mo.** Date signed **9/23/40**

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

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 6,

District File Number 1040-2672

Date Filed OCT 8 1940

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 Herma Purridge

Licensed Embalmer No. 3072

P. O. Address Curran 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, fact should be so stated above.