

FILLED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35346

State File No.

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. 62

1. PLACE OF DEATH

(a) County Lafayette  
(b) City or town Luxington, Mo  
(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 \_\_\_\_\_ (Specify whether  
In this community 1 years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(d) State MO (b) County Lafayette  
(e) City or town city 054  
(If outside city or town limits, write "RURAL")  
(d) Street No. city (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10  
year 1941 hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from Oct 15  
1941 to \_\_\_\_\_ 19\_\_\_\_

that I last saw her alive on Oct 15 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature 9 1/2 mo Duration

Due to \_\_\_\_\_

Due to 159

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 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 B. B. Brasher (M. D. or other) 0

Address Luxington, Mo Date signed 11/16/41

3. (a) PRINT FULL NAME Irma Katherine Martin

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex fe 1 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. 15 41  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 1 hr. - min

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Le Roy Martin

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

14. Maiden name Anna Parratt

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

16. (a) Informant Le Roy Martin

(b) Address Luxington, Mo

17. (a) Burial (b) Date thereof Oct. 16-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luxington, Mo

18. (a) Signature of funeral director Winkler

(b) Address Luxington, Mo

19. (a) Oct 16/41 (b) Delia Bates  
(Date received local registrar) (Registrar's signature)

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

4  
26

*Becker*

RECEIVED  
District Health Officer No. 8  
District File Number 17-07-11  
Date Filed 41

**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. A. Embalmey*

Licensed Embalmer No.....

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, fact should be so stated above.**