

JAN 10 1942

Registration District No. 844

Primary Registration District No. 6157

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Stone
 (b) City or town Rural - Ponce de Leon
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
(Specify whether
 In this community most of life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone
 (c) City or town rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Highlandville - Star Route
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21st
 year 1941 hour 11-30 minute _____ M.
 21. I hereby certify that I attended the deceased from only saw him
once Dec 21 1941, to _____ 19____;
 that I last saw him alive on Dec 21 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis left side Body 1 year
 Duration _____

Due to _____
 Due to _____
 Other conditions § 32
(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 J. W. Haden (M. D. or other) _____
 Address Gosh Mo Date signed 12-23-41

3. (a) PRINT FULL NAME James Nathaniel Martin

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. 2 Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Sept. 8 - 1865
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation farming

11. Industry or business _____

12. Name Nathaniel Martin

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

14. Maiden name Susan Sims

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

16. (a) Informant Dallas Martin
 (b) Address Highlandville, Mo

17. (a) Burial (b) Date thereof Dec 25-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flood Cem.

18. (a) Signature of funeral director J. W. Magler
 (b) Address Clever, Mo.

19. (a) 12-30-41 (b) Ola Magler
(Date received local registrar) (Registrar's signature)

164

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

4
57

RECEIVED

District Health Officer No. 6,

District File Number 172-32

Date Filed JAN 6 1942

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.....

J. W. Maples

Licensed Embalmer No. 2985

P. O. Address.....

Clever, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43183
Registrar's No.

Registration District No. 844

Primary Registration District No. 6107

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural
(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 _____ years, months or days)

3. (a) PRINT FULL NAME James N. Martin

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

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

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

7. Birth date of deceased Sept 8 (Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 5 (if less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

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

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1941 Hour _____ Minute _____ M.

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

Immediate cause of death: Paralysis left side of body
Due to Cerebral Hemorrhage
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature J. H. Madson (M. D. or other) _____
Address 83rd Date signed 11-20-41

SUPPLEMENTARY

MOTHER FATHER

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

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

S-43183