

19247

No. 2  
9-4-41  
7-39  
X29

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUN 8 1943

Registration District No. 4499

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbina  
(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 58 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 102

(a) State..... (b) County..... 0

(c) City or town..... 0  
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME Mae Jones Martin

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased May 18 1882  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months    | Days      | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
|         | <u>59</u> | <u>II</u> | <u>16</u> | hr. .... min.        |

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

10. Usual occupation House Worker

11. Industry or business.....

12. Name Charles B. Martin

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

14. Maiden name Nannie Jones

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

16. (a) Informant Mrs. Iress D. Lyell

(b) Address Shelbina Mo.

17. (a) Burial (b) Date thereof May 6 1943  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina Mo.

18. (a) Signature of funeral director E. Lyell

(b) Address Shelbina Mo.

19. (a) May 22 43 (b) M. J. Good  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 4  
year 1943 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from 6-12-42, 19... to 5-3-43, 19...  
that I last saw her alive on 5-3-43, 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy

Due to.....  
Due to.....

Other conditions Infantile paralysis at 10 yrs  
(Include pregnancy within 6 months of death) unable to walk since

Major findings:  
Of operations..... 85  
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) (e) Means of injury 0

23. Signature A. M. Hood (M. D. or other)  
Address Shelbina Mo Date signed 5-11-43

Duration 1 yr  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

JUN 12 1943

RECEIVED

District Health Officer No. 10

District File Number 6-43-266

Date Filed JUN 7 1943

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.....

*E Hayes*

Licensed Embalmer No. 1487

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 337

Primary Registration District No. 4499

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Shelby  
(b) City or town Shelby  
(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 5-8 yrs (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME nee James Martin

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased May 18 - 1885  
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 15 (If less than one day) \_\_\_\_\_ min.

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

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

11. Industry of business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby  
(c) City or town Shelby Rural (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 May 4  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

5-19247