1. No. 2
d—2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20505

FILED JUL 8 1943

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 2808

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2820 Nicholson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution x (Specify whether
In this community 29 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48 3
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 2820 Nicholson
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Natividad Martinez
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Fe
5. Color or race W
6. (a) Single, married, widowed, divorced M
6. (b) Name of husband or wife Benito Martinez
6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased Sept 19 (Month) 1914 (Day) (Year)

8. AGE: Years 28 Months 89 Days 2 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Carlos Castro
13. Birthplace Mexico (City, town, or county) 3 (State or foreign country)
14. Maiden name Francisca Lenden
15. Birthplace Mexico (City, town, or county) 3 (State or foreign country)
16. (a) Informant Benito Martinez
(b) Address 2820 Nicholson
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Marys
18. (a) Signature of funeral director H. Tigerman & Sons
(b) Address K.C. Mo.
19. (a) 6-22-43 (Date received local registrar) (b) D. E. Brown Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1943 hour 9 a.m. minute M.
21. I hereby certify that I attended the deceased from Dec. 20, 1942, to June 21, 1943, that I last saw her alive on June 20, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis	6 mo.
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

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

23. Signature James Middleton (M. D. or other)
Address 824 N. Montgallan Date signed 6-21-43

(Licensed Embalmer's Statement on Reverse Side)

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 Francis Walton, Registered Apprentice No. 2744, working under my personal supervision.

Signed J. A. Reisman

Licensed Embalmer No. 2744

P. O. Address K.C. 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.

S. No. 2B
I—5-43
P I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ____

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2808

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas city
(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 years, months or days)
In this community ____

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 ____

3. (a) PRINT FULL NAME: Natividad Martinez
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: M
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Sept (Month) 19 (Day) 1930 (Year)

8. AGE: Years 28 Months 9 Days ____ If less than one day: ____ hr. ____ min.

9. Birthplace: ____ (City, town, or county) Mo. (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 1 year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis	
Intestinal tuberculosis	12-30-42 to 6-21-43
and Lungs tuberculosis	
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

131

20505