

Registration District No. **1**

Primary Registration District No. **3000**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkersville Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1018 E Jefferson**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 year** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Adair**
(c) City or town **Kirkersville** (If outside city or town limits, write "RURAL")
(d) Street No. **1018 E. Jefferson** (If rural, give location)
(e) Citizen of foreign country? **MO** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **EMORY AMOS MARTIN**

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

4. Sex **male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **single**

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

7. Birth date of deceased **Sept 13 1925**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	17	9	15	hr. _____ min. _____

9. Birthplace **Winnigan MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Roofing**

11. Industry or business **Same**

12. Name **Ada Amos Martin**

13. Birthplace **Green City MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Lawrence**

15. Birthplace **Melan MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ada Amos Martin**

(b) Address **1018 E Jefferson Kirkersville**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-1-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Hawkeye**

18. (a) Signature of funeral director **Summers Powell**

(b) Address **Kirkersville Mo**

19. (a) **7/6/43** (Date received local registrar) (b) **Mr. J. L. Weyand** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28** year **1943** hour **3** minute **45 P.** M.

21. I hereby certify that I attended the deceased from _____, 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 **Drowned by a blow on left temple from curbstone corner** - Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **18 3 3**

Major findings: Of operations **36**

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident 12.4**
(b) Date of occurrence **June 28, 1943**
(c) Where did injury occur? **Kirkersville, Adair Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Park
While at work? **no** (Specify type of place) (e) Means of injury **Drowned**

Signature **W. G. Summers** (M.D. or other) **Corner**

Address **Kirkersville Mo.** Date signed **7/6/43**

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

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

www

RECEIVED

District Health Officer No. 10

District File Number 2-43-118 D

Date Filed JUL 30 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 W.C. Summers

Licensed Embalmer No. 3159

P. O. Address Ficksville 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.