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No. 2
-2-43
-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 20 1943

Registration District No. 357

Primary Registration District No. 3069

Registrar's No. 2558

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6330 Clayton Road
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No. 6330 Clayton Road
(If rural, give location)

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

3. (a) PRINT FULL NAME Joseph V. Martin

3. (b) If veteran, name war World War #2

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 December 11th, 1919
(Month) (Day) (Year)

8. AGE: Years 23 Months 11 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Soldier U. S. Army (Discharged)

11. Industry or business _____

12. Name John M. Martin

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

14. Maiden name Florence McCormick

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

16. (a) Informant John M. Martin
(b) Address 6330 Clayton Road

17. (a) Burial (b) Date thereof 11/19/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address 6633 Clayton Road

19. (a) NOV 19 1943 (b) E. S. McKarran, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th, year 1943 hour 4:30 minute _____ A M.

21. I hereby certify that I attended the deceased from Nov 12th, 1943, to Nov 17th, 1943
that I last saw him alive on Nov 16 1943, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Tera-toma, left testicle, 1 yr +</u>	
<u>with (Male, new)</u>	
Due to <u>Metastasis to</u>	
<u>lungs and base of</u>	
Due to <u>left neck,</u>	

Other conditions _____
(Include pregnancy within 3 months of death)

Operation, Nov 15 43 (From history)

Major findings: Tera-toma left testicle
Of operations: (Taken from US Army Correspondence)

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) No

(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. C. Landree (M. D. _____)
437 University Club Bldg.
Address St. Louis, Mo. Date signed 11-17-43

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

MOTHER FATHER

DEC 3 1946

APR 7 1948

DEC 20 1943

APR 20 1948

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.....
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.