

FILED AUG 17 1944

Registration District No. 377

Primary Registration District No. 6170

Registrar's No.

1. PLACE OF DEATH

(a) County Stone

(b) City or town Salena, Mo. 19-2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 McWhorter, Jr.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community About 53
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone

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

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

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

3. (a) PRINT FULL NAME Delia Martin

3. (b) If veteran, name war: ✓

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 1944 hour 6:00 minute 10 P. M.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife George Martin

6. (c) Age of husband or wife if alive 1 years 1876

7. Birth date of deceased: Oct (Month) 1 (Day) 1876 (Year)

21. I hereby certify that I attended the deceased from July 18 to July 18, 1944
that I last saw him et. alive on July 18
and that death occurred on the same date and hour stated above.

8. AGE: Years 67 Months 9 Days 26 If less than one day hr. min.

Immediate cause of death Branch of pneumonia

Due to Senility

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

Due to Senility

Other conditions: 107
(Include pregnancy within 3 months of death)

10. Usual occupation Naval mtl.

Major findings: Of operations:

11. Industry or business:

Of autopsy:

12. Name Jim Whitehead

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

14. Maiden name Virginia Williams

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

16. (a) Informant Frank Whitehead

(b) Address Elbert, Mo.

17. (a) Funeral (b) Date thereof July 28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parcel P.O. - Near Elbert, Mo.

18. (a) Signature of funeral director Elliott J. Cheatham

(b) Address Salena, Mo.

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

While at work? (Specify type of place) (c) Means of injury 0

23. Signature A. G. Cuthbert, M.D. (M. D. or other)

Address Stone, Mo. Date signed 7/28/44

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

RECEIVED

District Health Officer No. 6;

District File Number 844-922

Date Filed AUG 15 1944

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 *Everett G. Cheatham*

Licensed Embalmer No. 3870

P. O. Address *Salena, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 63. yr. (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Nelia 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 1 - 1900
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 0 (If less than one day, _____ min.)
9. Birthplace Mo.
(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 _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 7-28-44 (b) Nellie Tromby
(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 July Year 1944 Day _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 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) _____
Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

7-30-44

28962