

FILED OCT 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30540

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri-Meth-Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeKalb
(c) City or town Osborn Mo.
(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 U

3. (a) PRINT FULL NAME INEZ B. Martin

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

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife A. E. Martin 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased March 13 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Andrew Glasgow
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Marian McElwain
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant A. E. Martin
(b) Address Osborn Mo

17. (a) Burial (b) Date thereof Oct 12 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Osborn, Mo.

18. (a) Signature of funeral director J. G. Hays
(b) Address St. Joseph, Mo.

19. (a) 10-10-44 (b) Helen J. Pickle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1944 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 8, 1944, to Oct 9, 1944
that I last saw him alive on Oct 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage
extreme arteriosclerosis

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration
2 da
1 yr

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) (c) Means of injury

23. Signature H. A. Kearby (M. D. or other) M. D.
Address St. Joseph, Mo. Date signed 10-10-44

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

MOTHER FATHER

B C D

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. G. Lopez*.....

Licensed Embalmer No. *952*.....

P. O. Address *Stewartville, Md.*.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. actRegistration District No. 42 Primary Registration District No. 1000 Registrar's No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(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 _____
years, months or days3. (a) PRINT FULL NAME Judy B. 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 in

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

7. Birth date of deceased march 13 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 act days 19
year 1947 mar. _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death hemiaarteriosclerosisDue to Myocardial Ch

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death) 131

Major findings: _____

Of operations _____

Of autopsy _____

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

SUPPLEMENTAL

MEDICAL CERTIFICATION
act 19
1947
hemia
arteriosclerosis
Myocardial Ch
131
5:40

30540