

S. No. 2  
M-9441  
v. 5-17-39  
I X29484

State File No. \_\_\_\_\_  
Registrar's No. 296

Registration District No. 6/1944

Primary Registration District No. 3008

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
state hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days) 17 days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cape Girardeau  
(c) City or town Allenville 14  
(If outside city or town limits, write "RURAL")  
(d) Street No. none  
(If rural, give location) 2  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARIE MARTIN  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 7  
year 1944 hour 2 minute 15 P. M.  
21. I hereby certify that I attended the deceased from Aug 21, 1944, to Sept 7, 1944  
that I last saw her alive on Sept 6, 1944  
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race Colored 6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife Robert Martin 6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased May 12, 1899  
(Month) (Day) (Year)

Immediate cause of death meniscal exhaustion  
Duration 3wks

8. AGE: Years 45 Months 3 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions malnutrition & dehydration 3wks  
(Include pregnancy within 3 months of death)

9. Birthplace Cape Girardeau mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation housewife

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name John Green  
13. Birthplace Alabama  
(City, town, or county) (State or foreign country)  
14. Maiden name D.K.  
15. Birthplace D.K.  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Reids etc. 11/2/44  
(b) Address Fulton, Mo  
17. (a) Removal (b) Date thereof Sept 7 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cape Girardeau, Mo  
18. (a) Signature of funeral director F. S. Sparks  
(b) Address Cape Girardeau, Mo  
19. (a) 9-7-1944 (b) Joseph M. ...  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature John J. Black (M. D. or other)  
Address Fulton, Mo Date signed 9/7/44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-5-44

**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

*Frank Sparks*

Licensed Embalmer No.

3455

P.O. Address

*Capo Guardian, 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.**