

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
 1003

FILED NOV 21 1944
 Registration District No. B1934

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____ St. Louis

(b) City or town _____ St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
 St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ 0
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME McDonald Martin

3. (b) If veteran, name war _____ Unknown

3. (c) Social Security No. _____ Unknown

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife _____ Unknown

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

7. Birth date of deceased April 19 1884
(Month) (Day) (Year)

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

60	6	5	hr. min.
----	---	---	----------

9. Birthplace Unknown Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

MOTHER FATHER

11. Industry or business _____

12. Name John Martin

13. Birthplace Unknown Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Clara Unknown

15. Birthplace Unknown Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant C. Oscar Johnson

(b) Address Grand and Washington Bldgs.

17. (a) Burial (b) Date thereof 10-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Fred M. Williams

(b) Address 4535 Washington Blvd.

19. (a) OCT 25 1944 (b) JTBredect
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1510 Market St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24
 year 1944 hour 12:30 minute 40 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
 Cerebral apoplexy

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

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 3

23. Signature James J. Fitzmaurice
 Address 1300 Clark Date signed 10-25-44
(M. D. or other)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Albert W. Hoppe
.....
.....
.....

Licensed Embalmer No. *1861*

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.