S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1944 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

103

State File No. 39599

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 10780

1. PLACE OF DEATH:

(a) County: St. Louis

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

(c) Name of hospital or institution: 4129 Clarence (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No.: 4129 Clarence Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME: WILLIAM H. MARTIN

3. (b) If veteran, name war: ____

3. (c) Social Security No.: 429-16-5162

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Vera

6. (c) Age of husband or wife if alive: 42 years

7. Birth date of deceased: March (Month) 20 (Day) 1900 (Year)

8. AGE: Years 44 Months 8 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace: Arkansas (City, town, or county) ____ (State or foreign country)

10. Usual occupation: Bricklayer

11. Industry or business: Small Arms Plant

MOTHER FATHER

12. Name: William A. Martin

13. Birthplace: Arkansas (City, town, or county) ____ (State or foreign country)

14. Maiden name: Ella L. Martin

15. Birthplace: Arkansas (City, town, or county) ____ (State or foreign country)

16. (a) Informant: Mrs. Vera Martin

(b) Address: 4129 Clarence Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/20/44 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: SULLIVAN BRO'S

(b) Address: 2849 N. Euclid Ave.

19. (a) DEC 18 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17th year 1944 hour 4:15 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from Nov 15, 1944, to Dec 17, 1944, that I last saw him alive on Dec 17, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis of the liver	1 mo.
Due to: Chronic alcoholism	
Due to: Syphilis	
Other conditions (Include pregnancy within 3 months of death): 30 g	

Major findings: Of operations: none

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): none

(b) Date of occurrence: none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? none (e) Means of injury: ____

23. Signature: Joscopelite O (M. D. or other) MD

Address: 4222 N. Grand Date signed 12/18/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. Jos. Scopelite
4222 N.Grand
Ce. 6825

1 oz 3.00 Pm

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 Robert L. Brinkman

Licensed Embalmer No. 3553

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.