

FILED FEB 6 1945
 Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 412

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
(Specify whether
 In this community 55 years
years, months or days)

3. (a) PRINT FULL NAME JOSEPH MARTIN

3. (b) If veteran, name war NO 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Margaret Martin 6. (c) Age of husband or wife if alive unk years
 7. Birth date of deceased Dec 23 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 3 If less than one day hr. min.

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

10. Usual occupation Retired Stationary Engineer

11. Industry or business _____

MOTHER FATHER

12. Name Maurice Martin
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Slattery
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant John L. Martin

(b) Address 3610 East 27th St

17. (a) Burial (b) Date thereof Jan 29, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Quirk & Tobin Co

(b) Address 204 Lincoln

19. (a) 1-26-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3537 Jefferson
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26th day Jan
 year 1945 hour 8:30 minute A M.

21. I hereby certify that I attended the deceased from _____
Pathologist 19____
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction

Due to Biliary calculus

Due to Cholelithiasis

Other conditions Multiple biliary calculi in intestinal tract

Major findings: Of operations _____

Of autopsy As above

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Ernie Surval (M. D. number) 1-26-45
 Address Pathologist Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Charles M. Zwick

Licensed Embalmer No. 3774

P. O. Address Kansas City 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.