

7. S. No. 2
 OM-8-43
 Rev. 5-17-39
 X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **3490**
 Registrar's No. **2928**

FILED FEB 13 1945

Registration District No. **317** Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
 (a) County **Koch, St. Louis Co**
 (b) City or town **Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Roth Koch Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 hr 2 mo 9 days**
 In this community **6 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **0000**
 (c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
 (d) Street No. **1315 Biddle** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **JANETTE MARTIN**
 (b) If veteran, name war _____ (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **1** day **28** year **1945** hour **6 P.M.** minute _____ M.

4. Sex **Fem** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **MARRIED**
 (b) Name of husband or wife **PAUL MARTIN** 6. (c) Age of husband or wife if alive **?** years
 7. Birth date of deceased: (Month) **2** (Day) **13** (Year) **1903**

21. I hereby certify that I attended the deceased from **11-19**, 19**43**, to **1-28**, 19**45**; that I last saw her alive on **1-28**, 19**45**; and that death occurred on the date and hour stated above.

8. AGE: Years **41** Months **11** Days **16** If less than one day _____ hr. _____ min.

Immediate cause of death: **Pulmonary Tuberculosis - F. A.** Duration **3 yrs?**

9. Birthplace: (City, town, or county) **Mississippi** (State or foreign country)

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) **13 ft 1**

10. Usual occupation **Nil**

11. Industry or business **Nil**

12. Name **GEORGE BOOCH**

13. Birthplace: (City, town, or county) **?** (State or foreign country) **?**

14. Maiden name **Maggie Elliott**

15. Birthplace: (City, town, or county) **Mississippi** (State or foreign country)

16. (a) Informant **PATIENT**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **2-2-45** (Month) (Day) (Year)

(c) Place: burial or cremation **Oakland Mississippi**

18. (a) Signature of funeral director **Ellis Funeral Home**

(b) Address **2820 Steadford St**

19. (a) **JAN 10 1945** (b) **J. M. Malvern** (Registrar's signature)

Major findings: Of operations _____
 Of autopsy **Pulmonary Tuberculosis**

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) Means of injury _____

Signature **Samuel S. Roman** (M. D. or other) **Dr. Roth Koch Hospital** Date signed **1/29/45**

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

L. Bayless

Registered Apprentice No.

M

working under my personal supervision.

Signed

Lommie Bayless

Licensed Embalmer No.

29346

P. O. Address

St Louis 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.