S. No. 2
DM—2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25933 7350

FILED SEP 1 1945 818

Registration District No.

Primary Registration District No. 1003

Registrar's No.

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 3110 Market St.
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 18

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3110 Market St. 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sellie Martin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years About 44 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Charlie Martin
13. Birthplace (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Lillie Resper
15. Birthplace (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Sam Crowley
(b) Address 2628a Spruce St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25 '45 (Month) (Day) (Year)
(c) Place: burial or cremation Marks, Miss.

18. (a) Signature of funeral director Russell Undt. Co.
(b) Address 2732 Pine St.

19. (a) AUG 23 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st year 1945 hour 9 minute 10 A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Ruptured Aortic Aneurysm

Due to

Other conditions 30
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury 3

23. Signature Dr. Alfred Perry (M.D. or other) Dy Cor.

Address 1300 Clark Date signed 8-23-45

(Licensed Embalmer's Statement on Reverse Side)

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.....Joel Russell.....

Licensed Embalmer No.....4112.....

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.