V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26895

State File No. .....

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 868

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hospital No. 2 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution State Hospital (Specify whether In this community 20 Yrs. 7 Mos. 9 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 11

(c) City or town Chillicothe 1 (If outside city or town limits, write "RURAL")

(d) Street No. None 1 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Katherine K. Martin

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Lawrence Martin

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

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

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Kansas (City, town, or county) 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name William Kennedy
13. Birthplace Kansas (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Katherine (?)
15. Birthplace Kansas (City, town, or county) 1 (State or foreign country)

16. (a) Informant None

(b) Address .....

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe

18. (a) Signature of funeral director Meinershagen Funeral Home

(b) Address Chillicothe Mo

19. (a) 8-10-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th. year 1945 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from 7/19/45, 19..., to 8/9/45, 19..., that I last saw her alive on 8/9/45, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to .....

Due to .....

Other conditions None (Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy .....

Duration: Unknown Long 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) None

(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 George M. Boteler (M. D. or other)

Address State Hospital No. 2 Date signed 8/9/45

St. Joseph, Missouri

1377

(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

Was Embalmed, Registered Apprentice No.

working under my personal supervision.

Signed E Beckett

Licensed Embalmer No. 3227

P. O. Address Chillicothe 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.