

FILED SEP 22 1945

State File No. 7

Registration District No. 317

Primary Registration District No. 306 B 076

Registrar's No. 2230

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

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: 8149 GRAVOIS Miller Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Mo
(Specify whether)

In this community Life
years, months or days

3. (a) PRINT FULL NAME Celia J Martin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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: June 8, 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace: Washington Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Seamstress

11. Industry or business In her own home

12. Name V. C. Martin

13. Birthplace St Louis Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hite

15. Birthplace Allegheny Pa
(City, town, or county) (State or foreign country)

16. (a) Informant Chester Prince

(b) Address Liberty Mo

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

(c) Place: burial or cremation Graves 707, Mo

18. (a) Signature of funeral director Fred M. Williams

(b) Address 4535 Washington

19. (a) 9-18-45 (b) E. P. Dehaene
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

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

(d) Street No. 8149 GRAVOIS
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27
year 1945 hour 4 PM minute _____ M.

21. I hereby certify that I attended the deceased from July 16, 1945, to Aug 9, 1945, that I last saw her alive on Aug 9, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death _____
arteriosclerosis

Due to _____
93%

Due to _____
Chronic myocarditis

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

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy _____

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)

(b) Means of injury _____

23. Signature Royal C. McLean (M. D. or other) _____
Address Perkwood Mo Date signed 9-11-45

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John Agnoski

Licensed Embalmer No.....

3398

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.