S. No. 2
M—5-43
. 5-17-39
> I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35612

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9568

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:
ST. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community 25 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 2611 N. Garrison
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Julia Martin

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife William C. Martin

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Feb (Month) 22 (Day) 1871 (Year)

8. AGE: Years 74 Months 8 Days 12 If less than one day hr. min.

9. Birthplace Springfield, Ill (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Edward Orleans
13. Birthplace Unknown (City, town, or county) – (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace " " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Wm C. Martin 1
(b) Address 2611 N. Garrison Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 6 45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home
(b) Address 4828 Nat'l Bridge Bl

19. (a) NOV 5 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4th
year 1945 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct 26, 1945, to Nov 4, 1945
that I last saw he alive on Nov 4, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac decompensation	?
Due to: pulmonary congestion	
Due to: Arteriosclerotic Heart Disease	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

23. Signature Cornelia E. Motley (M. D. or other)
Address City Hosp. 1515 Lafayette Date signed 11-4-45

(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 John A. Mlinar

Licensed Embalmer No. 4186

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.