

FILED JAN 8 1946

Registration District No. 1000

Registrar's No. 1436

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: 716 No 6 St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr
In this community abt 50 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARTHA ANN HALL
3. (b) If veteran, name war 2nd
3. (c) Social Security No. 21004

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced, wid
6. (b) Name of husband or wife William E Hall
6. (c) Age of husband or wife if alive, years 1866
7. Birth date of deceased July 19 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER
12. Name James Price
13. Birthplace Ill (City, town, or county) (State or foreign country)
14. Maiden name Margaret (Singerman)
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Cecelia G. Dickson
(b) Address St. Joseph Mo

17. (a) B (b) Date thereof Dec 31 1945 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem.

18. (e) Signature of funeral director St. Joseph Funeral Home

(b) Address St. Joseph Mo

19. (c) Jan 3 - 1946 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2417 No 4 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1945 hour 10:45 minute 0 M.
21. I hereby certify that I attended the deceased from 12/21/45
to 12/29/45, 1945
that I last saw her alive on 12/29/45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of uterus & bladder
Duration 1 yr.

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations: 441
Of autopsy: 441

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) (e) Means of injury _____

23. Signature W. Buchanan (M. D. or other)
Address St. Joseph Mo Date signed 12/29/45

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

24 1946

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 Roy Plummer
Licensed Embalmer No. 2435
P. O. Address St Joseph

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.