

**FILED** 1946 15 10 16  
Registration District No. 280

Primary Registration District No. 6-9-64 4421

Registrar's No. 21

**1. PLACE OF DEATH:**  
(a) County Platte  
(b) City or town Parkville *Pettis*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 48 yrs years, months or days

**3. (a) PRINT FULL NAME** Everett Harold Martin  
**3. (b) If veteran** World war 1 **3. (c) Social Security name** 496-01-5851

**4. Sex** Male **5. Color** White **6. (a) Single, widowed, married, divorced** Single  
**6. (b) Name of husband or wife if alive** none **6. (c) Age of husband or wife if alive** none years  
**7. Birth date of deceased.** Feb. 20 1897  
(Month) (Day) (Year)

**8. AGE:** Years 48 Months 10 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Parkville Mo  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Laborer & Farmer

**11. Industry or business** Chain & Stock

**12. Name** Samuel A Martin

**13. Birthplace** Parkville Mo  
(City, town, or county) (State or foreign country)

**14. Maiden name** Mary Agnes Findley

**15. Birthplace** St. Joseph Mo  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Henry Martin

**(b) Address** Parkville Mo

**17. (a) Burial** Burial **(b) Date thereof.** \_\_\_\_\_ (Month) (Day) (Year)  
**(c) Place: burial or cremation.** Parkville

**18. (a) Signature of funeral director** Edward R Francis

**(b) Address** Parkville Mo

**19. (a) 1-7-46** **(b) Mrs Ophelia Rollins**  
(Date received local Registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County Platte  
(c) City or town Rural Parkville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3 1/2 miles East  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country none

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Jan day 7  
year 1946 hour 12 minute 14 A.M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of the skull  
Due to auto accident  
Due to \_\_\_\_\_

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

**22. If death was due to external cause, specify 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** Tom H. Hulitt **Coroner**  
**Address** Platte City Mo. **Date signed** 1-7-46

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**ADDITIONAL SUPPLEMENTARY INFORMATION**

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

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

**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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Leland H. Frances  
Licensed Embalmer No. 3451  
P. O. Address Parkeville 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7-27  
Registrar's No. 27

Registration District No. 280 Primary Registration District No. 7421

1. PLACE OF DEATH:

(a) County Platte  
(b) City or town Parkville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

3. (a) PRINT FULL NAME Everett H. Martin

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jul 20 1899  
(Month) (Day) (Year)

8. AGE: Years 48 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of the skull

Due to was hit by auto while walking on highway  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 1-7-46  
(c) Where did injury occur? Highway  
(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 TOM H. Hullett (M.D. or other) \_\_\_\_\_  
Address Platte City Mo Date signed 1-7-46

**SUPPLEMENTARY**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
1706  
1721

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1810 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3705