

FILED MAR 18 1946 318

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2113

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:
Homer G. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community 23 Years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2714 Dickson St.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Rev. John I. Martin.

3. (b) If veteran, name war _____ 3. (c) Social Security No. 194-10-4624

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lillie Martin 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased March 7 1901
 (Month) (Day) (Year)

8. AGE: Years 44 Months 11 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Tuckermah Ark.
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
 12. Name Frank Martin
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Katie Smith
 15. Birthplace Tenn.
 (City, town, or county) (State or foreign country)

16. (a) Informant Lillie Belle Martin
 (b) Address 2714 Dickson St.

17. (a) Burial (b) Date thereof 3-8-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park Cem. Ellis Funeral Home

18. (a) Signature of funeral director _____
 (b) Address 2820 Stoddard St.

19. (a) MAR 4 1946 J. F. Brusch
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st
 year 1946 hour 9:15 minute am

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 _____

Cerebral apoplexy
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

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)
 Means of injury 3
 23. Signature J. F. Brusch (M. D. or other) _____
 Date signed 3/4/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10332

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 L. Boykin

, Registered Apprentice No. my

working under my personal supervision.

Signed Lornnie Boykin

Licensed Embalmer No. 2946

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.