

FILED SEP 18 1946

Primary Registration District No. 4277

Registrar's No. 95

1. PLACE OF DEATH:

(a) County LAWRENCE
(b) City or town VERONA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 62 YRS. years, months or days

3. (a) PRINT FULL NAME SHIRL MARTZ

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

4. Sex Male 5. Color or race White 6. (a) Single; widowed, married, divorced Widowed

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

7. Birth date of deceased JAN. 15, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>8</u>	<u>25</u>	hr. _____ / min. _____

9. Birthplace Sydney Co., Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation BLACK SMITH

11. Industry or business RETIRED

12. Name HIRAM MARTZ 9

13. Birthplace NO RECORD 9

14. Maiden name MARY E. HARTMAN

15. Birthplace NO RECORD 9

16. (a) Informant MRS. MONROE HILLHOUSE

(b) Address VERONA, MO.

17. (a) BURIAL (b) Date thereof 9-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SPRING RIVER CEM.

18. (a) Signature of funeral director HING FUL HOME

(b) Address HURON, MO.

19. (a) 9-14-1946 (b) Dr. McNeil
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11
year 1946 hour 12:25 minute _____ A. M.

21. I hereby certify that I attended the deceased from July 10, 1946 to Sept. 11, 1946; that I last saw him alive on Sept. 11, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Sigmoid
Fluxus of Colon

Due to _____
Due to _____

Other conditions Peritonitis abd. sup. with
(Include pregnancy within 3 months of death) with hyperstension & unilateral spastic

Major findings: Paraplegia PHYSICIAN _____

Of operations _____
Of autopsy H.F.
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 F. Avery Watson M. D. or other PO.
Address Verona, Mo. Date signed Sept. 11, 46

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

RECEIVED

District Health Officer No. 6,

District File Number 946-966

Date Filed SEP-16-1946

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 K. J. White

Licensed Embalmer No. 4240

P. O. Address AURORA, 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.