

FILED JAN 7 1947

Registration District No. **149**Primary Registration District No. **1002**Registrar's No. **5455**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **KANSAS CITY, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
DeVine Basis Foundation Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Day**
 (Specify whether years, months or days) **29 Yrs.**

3. (a) PRINT FULL NAME **Mrs. Minnie Martin**

3. (b) If veteran, name war **No.**
 3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Charles H. Martin**
 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **November 8, 1872**
 (Month) (Day) (Year)

8. AGE: Years **74** Months **1** Days **19**
 If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER {
 12. Name **William Alban**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Marvel**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Henrietta Bosley**
 (b) Address **5904 E. 32nd. St.**
 17. (a) **Burial** (b) Date thereof **12/30/46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Floral Hills**
 18. (a) Signature of funeral director **Earp & Sons**
 (b) Address **4139 E. 15th. St.**

19. (a) **12-28-46** (b) **Steraldine Holmes**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5904 E. 32nd. St.**
 (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 **27**
 year **1946** hour **12** minute **46** **Noon.**
 21. I hereby certify that I attended the deceased from **Dec. 26 - 1946**
 , 19 **46**, to **Dec 27**, 19 **46**,
 that I last saw h. **cc.** alive on **Dec. 27**, 19 **46**,
 and that death occurred on the date and hour stated above.

Immediate cause of death

Myocardial failure **5 days**
 Due to **Chronic Interstitial**
nephritis **20+ years**
 Due to **years**

Other conditions
 (include pregnancy within 3 months of death)

Major findings:

Of operations **131a**
 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 **J. J. ...** (M.D. or other)
 Address **918 Oak St, K.C. 6 Mo.** Date signed **12/27/46**

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.....

Licensed Embalmer No.....

P. O. Address.....

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.