

0-2
5-43
7-39
X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43605

State File No. _____

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Newton County
(b) City or town Stella, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stella Hospital 0
(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 Maude Martin

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

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Chas Martin 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Sept. 18, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 1 18 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Phillip Sutherland
13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Triplet
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Martin
(b) Address Peoria, Okla.

17. (a) Burial (b) Date thereof 11-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Owsley Cemetery

18. (a) Signature of funeral director Chas. W. Williams
(b) Address Goodman, Mo.

19. (a) 10 1947 (b) Alpha Dyar
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Okla. (b) County " 999
(c) City or town Peoria 94
(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 11 day 4
year 1946 hour 6 minute 55 a.

21. I hereby certify that I attended the deceased from 5-21, 1946, to 11-4, 1946
that I last saw h. aw alive on 11-4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: g m A
Of operations _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Stella m. A. (M. D. or other)
Address Stella mo Date signed 1-3-47

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

369

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. New York

District File Number 147-11

Date Filed 1-20-47

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.