

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **7991**
 Registrar's No. **411**

FILED MAR 31 1947

Registration District No. **42** Primary Registration District No. **1000**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Saxton Nursing Home 2421 Francis
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
 In this community 3 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Fannie B. Martin
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female **5. Color or race** white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife David Martin
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 1 1863
 (Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 18
 If less than one day _____ hr. _____ min.

9. Birthplace Terre Haute Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name John Peyton
13. Birthplace unknown unknown
 (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown Indiana
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Martin
(b) Address Highland, Kansas

17. (a) removal **(b) Date thereof** 3/19/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland, Kansas

18. (a) Signature of funeral director Neaton - Bowman
(b) Address St. Joseph, Mo

19. (a) 3-25-47 **(b) E. L. Jenkins**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2421 Francis
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th
 year 1947 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from
March 17, 1947, to March 19, 1947
 that I last saw her alive on March 19, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Infarction
 Duration 4 days

Due to _____

Due to _____

Other conditions: 233B
 (Include pregnancy within 3 months of death)

Major findings:
 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?

(Specify type of place) _____
While at work? _____ **(e) Means of injury** 0

23. Signature J. De Mays (M. D. or other)

Address 2801 Kenick St. Ofc. Ill. **Date signed** 3/20/47

JUL 15 1947

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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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 South St. Joseph 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.