

FILED MAY 12 1947

STANDARD CERTIFICATE OF DEATH

State File No.

597

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

1. PLACE OF DEATH:

(a) County Rushmore  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 yrs 1 mo 25 da  
(Specify whether years, months or days)  
In this community 4 years 1 month 25 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3206 Highland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Rose Mary Martin

3. (b) If veteran, name war No 3. (c) Social Security No. 712

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased December 12 1924  
(Month) (Day) (Year)

8. AGE: Years 22 Months 4 Days 22 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

12. Name Thomas F. Martin

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Julia Kearney  
(City, town, or county) (State or foreign country)

15. Birthplace K.C. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Victoria Martin

(b) Address 3310 Olive K.C. Mo.

17. (a) Buried (b) Date thereof May 7, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys-K.C. Mo.

18. (a) Signature of funeral director Thomas E. Quirk Funeral Home  
4316 Troost Ave. K.C. Mo.

(b) Address

19. (a) 5-5-47 (b) E. L. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 4 1947 year 1947 hour 3 minute 40 M.

21. I hereby certify that I attended the deceased from Jan 1 1947 to Feb 27 1947  
and that I last saw him alive on Mar 7 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary tuberculosis and epilepsy  
Due to both known

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1375

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?

23. Signature E. L. Jenkins (M.D. or other)

Address State Hospital # 2 Date signed 5/14/47

Duration  
5 months 14 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

File in 20 apt.

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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.....

*Thomas E. Jurek*

Licensed Embalmer No. ....

3775

P. O. Address.....

*R.C. Mc*

**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.**