No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 1 1948

Registration District No. 1948 8

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2006

4535
State File No.
Registrar's No. 126

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 827 W. Turner
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No.: 827 W. Turner 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: Jennie Martin
3. (b) If veteran, name war: None
3. (c) Social Security No.: No
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Charlie Martin
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: September (Month) 10 (Day) 1875 (Year)

8. AGE: Years 72 Months 4 Days 27 If less than one day — hr. — min.

9. Birthplace: Grant County, (City, town, or county) Indiana (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: In home

MOTHER FATHER
12. Name: Samuel Cox
13. Birthplace: Indiana (City, town, or county) (State or foreign country)
14. Maiden name: — McCoy
15. Birthplace: — Indiana (City, town, or county) (State or foreign country)

16. (a) Informant: Margaret Davis
(b) Address: 827 W. Turner
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-9-1948 (Month) (Day) (Year)
(c) Place: burial or cremation: East Lawn Cem
18. (a) Signature of funeral director: J.W. Klingner & Co.
(b) Address: Springfield, Missouri
19. (a) 2-8-48 (Date received local registrar) (b) M. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 7 year 1948 hour 4 minute 00 A.M.
21. I hereby certify that I attended the deceased from several yrs. ago to 2/7/48 19..., that I last saw her alive on 2/6/48 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic nephritis	3 yr
Due to: Arterio-sclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: 13
Of autopsy: 13

PHYSICIAN
Underline the cause of 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? 0
While at work? (Specify type of place) (e) Means of injury:
23. Signature: J. B. Lemmon (M. D. or other) M.D.
Address: 600 Medical Arts Bldg. Springfield, Mo. Date signed 2/7

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

JUN 14 1943

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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Spring Field

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.