

No. 2
147
17.39

FILED MAR 29 1948

Registration District No. **157**

Primary Registration District No. **3028**

Registrar's No. **67**

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **316 Fulton St.,**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **49**

(c) City or town **Carthage**
(If outside city or town limits, write "RURAL") **1**

(d) Street No. **316 Fulton St.,**
(If rural, give location) **3**

(e) Citizen of foreign country? **No** (Yes or No) **0**

If yes, name country.....

3. (a) PRINT FULL NAME **James MARTIN**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Wid**

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|-----------------|-------|--------|------|----------------------|
| About 88 | | | |hr.min. |

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

10. Usual occupation **Unknown** **9**

11. Industry or business.....

12. Name **Unknown** **9**

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

14. Maiden name **Unknown** **9**

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

16. (a) Informant.....

(b) Address.....

17. (a) **Burial** (b) Date thereof **3-19-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Ed. C. Ulmer**

(b) Address **Carthage, Mo.**

19. (a) **3-19-1948** (b) **L. B. Clinton, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11th.**
year **1948** hour **2:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **Head not attended** 19.....
that I last saw him **alive** on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure**

Due to **Centesis Sclerosis**

Due to **Senile Atrophy**

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

Major findings:
Of operations..... **97**

Of autopsy..... **97**

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?.....
(Specify type of place)

While at work..... (Specify type of place) (Month) (Day) (Year)

Signature **L. B. Clinton, M.D.** (M. D. or other)

Address **2114 Poplar** Date signed **3/19/48**

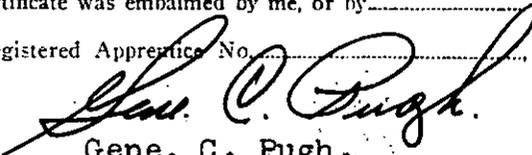
WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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..... 
Gene. C. Pugh.

Licensed Embalmer No..... 4231

P. O. Address..... Carthage, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 157Primary Registration District No. 3021Registrar's No. 67

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 days3. (a) PRINT
FULL NAME JAMES MARTIN

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Unknown6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE all 88 Years Months Days If less than one day _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL.")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 11 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

5-9026