

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **25401**

FILED SEP 7 1948

Registration District No. **11**Primary Registration District No. **5041**Registrar's No. **74**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Rural Flat Creek Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 Block E. of Cassville on 44 hy.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **15 years**
years, months or days

3. (a) PRINT
FULL NAME**Joel Alfred Martin**3. (b) If veteran,
name war _____3. (c) Social Security No.
none

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Josephine Martin** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **May 18, 1872**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 2 26 hr. min.

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

10. Usual occupation **Farmer**11. Industry or business **Farming**

12. Name **James W. Martin**
13. Birthplace **McDonald County, Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mollinda McGuire**
15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. S. T. Chase**
(b) Address **Cyclone, Mo.**

17. (a) **Burial** (b) Date thereof **8/18/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **County Cemetery**

18. (a) Signature of funeral director **W. C. Roon**
(b) Address **1303 Main, Cassville, Mo.**
19. (a) **Aug 23-1948** (b) **Grace Williams**
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **E. edge of Cassville on 44 hy.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **14**
year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 **Apparently a heart attack at home.** Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations **95C**

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 **3**

23. Signature **J. D. Buchanan** (M. D. or other) **Coroner**
Address **Mount Mo** Date signed **8-18-48**

RECEIVED

District Health Officer No. 6,

District File Number 948-990

Date Filed SEP 3 1948

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.