

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31250**
Registrar's No. **8149**

FILED OCT 1 1948
Registration District No. **1003**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3908 FLAD AV. 1
(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 **Mo.** (b) County **033**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" _____)
(d) Street No. **3908 FLAD AV. 1**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MYRTLE MARTIN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **15**
year **1948** hour **2** minute **20** p.m.
21. I hereby certify that I attended the deceased from
6-22, 19**46**, to **9-15**, 19**48**.
that I last saw ~~her~~ alive on **9-15**, 19**48**.
and that death occurred on the date and hour stated above.

4. Sex **FE.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W 9**
6. (b) Name of husband or wife **JOHN J. MARTIN** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **FEBRUARY 14-1888**
(Month) (Day) (Year)

Immediate cause of death **Generalized Carcinomatous of Abdomen (metastatic): 0** Duration **unk.**
Due to **Adenocarcinoma of ovary. -** **unk.**
Due to _____
Other conditions **H9**
(Include pregnancy within 3 months of death)

8. AGE: Years **60** Months **7** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation **HOUSEKEEPER. 1.**

11. Industry or business **OWN.**

12. Name **DAN MARKS.**

13. Birthplace **TENNESSEE. 1**
(City, town, or county) (State or foreign country)

14. Maiden name **ANNIE OAKLEY**

15. Birthplace **TENNESSEE. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Annabel Tremaine**

(b) Address **3908 FLAD AV.**

17. (a) **BURIAL** (b) Date thereof **SEPT 18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lakewood Park Cem**

18. (a) Signature of funeral director **E. J. Schmir**

(b) Address **3125 Lafayette Av.**

19. (a) **SEP 17 1948** (b) **J. F. Bedecko**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings: **Adenocarcinoma of ovary with general abdominal metastases.**
Of operations _____
Of autopsy _____
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 **Frank G. Bailey** (M. D. or other) **unk.**
Address **3108 So. Grand** Date signed **9-17-48**

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.....

John B. ...

Licensed Embalmer No. *4814*

P. O. Address *3125 Lafayette Ave*

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.