

S. No. 300
OM-10-47
ev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 4 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33000**
Registrar's No. **4001**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Lakeside Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 68 hrs. 14 min.
 In this community 13 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Iowa (b) County Taylor 999
 (c) City or town Gravity (If outside city or town limits, write "RURAL")
 (d) Street No. XXX (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Sarah Morgan Martin
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month October day 2
 year 1948 hour 12 minute 14 P.M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife James Wilson Martin
 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from September 18, 1948 to October 2, 1948
 that I last saw her alive on 10-1-48
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: October 6th. 1862
 (Month) (Day) (Year)
 8. AGE: Years Months Days If less than one day
85 11 26 hr. min.

Immediate cause of death myocarditis
 Due to coronary thrombosis
 Due to arterio sclerosis

9. Birthplace: Cuba Illinois
 (City, town, or county) (State or foreign country)
 10. Usual occupation At Home

Other conditions Hypostatic pneumonia and senility, cerebral
 (Include pregnancy within 3 months of death)
 Major findings of operations hemorrhage 93d

MOTHER FATHER
 11. Industry or business _____
 12. Name Daniel Morgan
 13. Birthplace Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Ann Warriner
 15. Birthplace Ohio
 (City, town, or county) (State or foreign country)

Of autopsy None
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Helen Richmond
 (b) Address 1010 E. 27th. Street
 17. (c) Removal (b) Date thereof 10-4-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Gravity, Iowa
 18. (a) Signature of funeral director Freeman Mortuary
 (b) Address Kansas City, Missouri
 19. (a) 10-2-48 (b) Geraldine Holman
 (Date received local registrar) (Registrar's signature)

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) _____
 (c) Means of injury Myron Auld, Jr
 23. Signature Myron Auld, Jr (M. D. or other)
 Address 3504 G. road ave Date signed 10/2/48

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

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 *W. H. Bennett*

--- Licensed Embalmer No. *4438*

P. O. Address *K. C., 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.