

FILED JAN 6 1949

Registration District No. 207Primary Registration District No. 5753Registrar's No. 36

1. PLACE OF DEATH:

(a) County Maries
 (b) City or town Meta Rural Bernath
 (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 Six Months
 years, months or days)

3. (a) PRINT FULL NAME Samantha Amie Martin

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

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife John Martin 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased 3 6 1866
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 9 21 hr. min.

9. Birthplace BelleRive Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Harvey Pace
 13. Birthplace BelleRive Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Houseworth
 15. Birthplace BelleRive Illinois
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry Harvey(b) Address Meta, Missouri17. (a) Burial (b) Date thereof 12/29/1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Meta18. (a) Signature of funeral director Fred H. Gilbert(b) Address Dixon, Missouri19. (a) 12-29-48 (b) Charline Howard
(Date received local registrar) (Registrar's signature) 1948

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries 63
 (c) City or town Meta (If outside city or town limits, write "RURAL") 3
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27
year 1948 hour 4 minute _____ P. M.

21. I hereby certify that I attended the deceased from
Nov. 25 48 to Dec. 27 1948
 that I last saw her alive on Dec. 27 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death
Left Ventricular Failure

Duration

2 hrs.Due to Cerebral ApoplexyDue to HypertensionOther conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations g3w

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 LSignature S. W. Barton (M. Director) D.O.
Address Meta, Mo. Date signed Dec 29 48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 5 1949

JAN 18 1949

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.

1272719+8

Signed..... *Maurice E. Schierba*

Licensed Embalmer No..... 4505

P. O. Address..... Dixon, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Mani Boone Twp
(b) City or town Rural
(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 6 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Samantha A. Martin

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased March 6 (Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days _____ (If less than one day, hr. min.)

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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-22-48 (b) Pauline Howard (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mani
(c) City or town meta (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 _____ Year 1948 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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

USE PREVIOUS EDITIONS OF THIS FORM FOR RECORD

S-40766