

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1949

State File No. 386

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 1

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

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Butler | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard | |
| b. CITY, OR TOWN Poplar Bluff (Liberty) | | c. CITY (If outside corporate limits, write RURAL and give township) Rural (Liberty) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hospital | | d. STREET ADDRESS (If rural, give location) R.F.D. # 2, Dexter | |

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|-------------------------------------|-------------------------|------------------------------|-------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Maude | b. (Middle) Elizabeth | c. (Last) Martin | 4. DATE OF DEATH (Month) (Day) (Year) Jan. 1, 1949 |
|-------------------------------------|-------------------------|------------------------------|-------------------------|--|

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|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|------|------|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 10, 1885 | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months | IF UNDER 2 HRS. Days | Hour | Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Bardstown, Kentucky | 12. CITIZEN OF WHAT COUNTRY? U. S. |
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|--|---|---|
| 13a. FATHER'S NAME William Ice | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE John Martin |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME Clyde Martin, Dexter, Mo. | ADDRESS _____ |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 57% | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? D |
|---|--|--|

22. I hereby certify that I attended the deceased from **Dec 16, 1948** to **Jan 1, 1949** that I last saw the deceased alive on **Jan 1, 1949**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) H. H. Strickland MD | 23b. ADDRESS Poplar Bluff Mo | 23c. DATE SIGNED 1-4-49 |
|--|--|-----------------------------------|

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|--|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE 1-3-49 | 24c. NAME OF CEMETERY OR CREMATORY Dexter Cemetery | 24d. LOCATION (City, town, or county) (State) Dexter, Missouri |
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| DATE REC'D BY LOCAL REG. 1-5-49 | REGISTRAR'S SIGNATURE H. H. Strickland | 25. FUNERAL DIRECTOR'S SIGNATURE Strickland-Kainey | ADDRESS Dexter, Mo. |
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RECEIVED
District Health Office, No. 2,
District File Number 1049-52
Date Filed 1-10-49

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 _____

Student-Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3479

P. O. Address Repton, 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.