

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25098

State File No. 6833

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellston	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If rural, give location) 6289 Horton Pl.	

3. NAME OF DECEASED (Type or Print) Rita Fern Martin			4. DATE OF DEATH (Month) (Day) (Year) August 4 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 5, 1946		9. AGE (In years last birthday) 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jonesburg, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Sylvester George Martin		13b. MOTHER'S MAIDEN NAME Mildred Imogene Blake		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sylvester Martin, 6289 Horton Pl.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 3 days
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polomyelitis		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (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.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Encephalitic sequelae			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 6 Polymyositis		20. AUTOPSY? YES <input checked="" 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) 316 0802	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8/2, 1949, to 8/5, 1949, that I last saw the deceased alive on 8/5, 1949, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Whigle J.M.D.		23b. ADDRESS 3211 St. Louis		23c. DATE SIGNED 8/5/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-8-49		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Normandy, Mo.	
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DATE REC'D BY LOCAL REG. AUG 3 1949		REGISTRAR'S SIGNATURE J. B. Sasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Albert G. Stepper*

Licensed Embalmer No. *2971*

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.