

FILED FEB 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 528

BIRTH NO. _____ REG. DIST. NO. 65 PRIMARY REG. DIST. NO. 4113 Registrar's No. 57

026

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

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Chariton	
b. CITY OR TOWN Brunswick		c. CITY OR TOWN Brunswick	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) William R. Martin			4. DATE OF DEATH (Month) (Day) (Year) Jan. 23 1950		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 13 1867		9. AGE (In years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Calhoun Co Ill	
12. CITIZEN OF WHAT COUNTRY? U SA					

13a. FATHER'S NAME Geo. W. Martin	13b. MOTHER'S MAIDEN NAME Mary E. Chisom	14. NAME OF MARRIED WIFE Nettie Baxter			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Della Hennington Brunswick Mo			
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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, asphyxia, 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) Chronic Nephritis.	DUE TO (b) Chronic Myocarditis				2 yrs.
II. OTHER SIGNIFICANT CONDITIONS	DUE TO (c)				595X
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) L	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **Sept 1**, 1944, to **Jan 23**, 1950, that I last saw the deceased alive on **Jan 23**, 1950, and that death occurred at **2 p** mm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. H. Fowler J. D.O.	23b. ADDRESS Brunswick, Mo	23c. DATE SIGNED 1-25-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Jan 27/50	24c. NAME OF CEMETERY OR CREMATORY Winfrey	24d. LOCATION (City, town, or county) (State) Near Bosworth Mo
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DATE REC'D BY LOCAL REG. 1-27-50	REGISTRAR'S SIGNATURE Mildred Boone	56	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. H. Heikard Mendon Mo
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RECEIVED

FFB 1

District Health Officer No. 8

District File Number

Date Filed 2-1-50

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, ~~XXXX~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed S. L. Shepard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.