

FILED FEB 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1732

BIRTH NO. _____ REG. DIST. NO. 201 PRIMARY REG. DIST. NO. 4315 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN La Plata		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN La Platamo.	
c. LENGTH OF STAY (in this place) 14 months			
d. FULL NAME OF HOSPITAL OR INSTITUTION Della Roan Nursing Home		d. STREET ADDRESS (If rural, give location) Highway 63	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) E. c. (Last) Martin	4. DATE OF DEATH (Month) (Day) (Year) Jan 30 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Dec. 24, 1876	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Hours 6	Min. ---
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Waddill	13b. MOTHER'S MAIDEN NAME Elva Craig	14. NAME OF HUSBAND OR WIFE F. Martin
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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 John Rice	ADDRESS South Bend, Ind.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Cerebral Hemorrhage	
		DUE TO (c) none	
II. OTHER SIGNIFICANT CONDITIONS		asthma	
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 28, 1950, to Jan 30, 1950, that I last saw the deceased alive on Jan 28, 1950, and that death occurred at 9 a. m., from the causes and on the date stated above.

23a. SIGNATURE H. O. Newborn (Degree or title) M.D.	23b. ADDRESS La Plata Mo	23c. DATE SIGNED Jan 31 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan 31 '50	24c. NAME OF CEMETERY OR CREMATORY Roseland Cemetery	24d. LOCATION (City, town; or county) (State) Pueblo Colorado
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DATE REC'D BY LOCAL REG. Feb 1 1950	REGISTRAR'S SIGNATURE M. O. B. Griffin 186	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Wilson	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 4/8/50
MACON COUNTY HEALTH DEPARTMENT
County File No. 259/17
Date Filed 4/8/50

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, or by.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Kenneth M. Wilson

Licensed Embalmer No. 4701

P. O. Address *La Plata 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.