

FILED MAR 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

0270
1

BIRTH NO. _____ REG. DIST. NO. 83 PRIMARY REG. DIST. NO. 5315 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WOOLDRIDGE Salina		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WOOLDRIDGE Salina	
c. LENGTH OF STAY (in this place) 35 yrs		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME			
3. NAME OF DECEASED (Type or Print) a. (First) NATHANIAL b. (Middle) WILSON c. (Last) MARTIN			4. DATE OF DEATH (Month) (Day) (Year) FEB. 22-1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 24-1884
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING	11. BIRTHPLACE (State or foreign country) 0
10b. KIND OF BUSINESS OR INDUSTRY FARMER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WILLIAM M. MARTIN		13b. MOTHER'S MAIDEN NAME SARAH MURRELL	14. NAME OF HUSBAND OR WIFE MRS DOLLY MARTIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS N.W. MARTIN - WOOLDRIDGE MO
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS 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 type="checkbox"/>			
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) _____	
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? _____	
22. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. L. Dickman M.D.		23c. DATE SIGNED Boonville Mo 2/25/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 25-1950	24c. NAME OF CEMETERY OR CREMATORY WALNUT GROVE CEM.	24d. LOCATION (City, town, or county) (State) BOONVILLE - MO
DATE REC'D BY LOCAL REG. 2/25/50		REGISTRAR'S SIGNATURE U. T. Meredith 720	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STEGNER FUNERAL HOME-BOONVILLE MO			

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

RECEIVED ³⁻²⁷⁻⁵⁰ FEB 27
District Health Officer No. 8
District File Number _____
Date Filed 3-2-50

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 James W. Segner
Licensed Embalmer No. 3780
P. O. Address Boston, MA

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.