

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. _____

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 St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		c. LENGTH OF STAY (in this place) 1 year	
d. STREET ADDRESS 4317 Washington Avenue		(If rural, give location) 0	

3. NAME OF DECEASED a. (First) Mary (Type or Print)		b. (Middle)		c. (Last) Martin		4. DATE OF DEATH (Month) (Day) (Year) May 2 1950	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2		8. DATE OF BIRTH unk. abt.		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? /	

13a. FATHER'S NAME William Ingram		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Armstrong Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Beulah Hutchison, Detroit, Mich.	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Coma - Possible Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH Undet.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jherx	
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 5-1, 19 50, to 5-2, 19 50, that I last saw the deceased alive on 5-2, 19 50, and that death occurred at 7:50p. m., from the causes and on the date stated above.

23a. SIGNATURE M. D. 2601 N Whittier St		23b. ADDRESS		23c. DATE SIGNED 5-3-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/7/50		24c. NAME OF CEMETERY OR CREMATORY Booker T. Washington		24d. LOCATION (City, town, or county) (State) Centerville Twp., Ill.	
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DATE REC'D BY LOCAL REG. MAY 4 1950		REGISTRAR'S SIGNATURE Blasabr		25. FUNERAL DIRECTOR'S SIGNATURE R. M. C. Green, 3517 Laclede Ave.		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Melvin E. Green

Signed.....
Student Embalmer

Licensed Embalmer No. *4428*

P. O. Address *St. Louis, 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.