

FILED NOV 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34156**
 BIRTH NO. _____ REG. DIST. NO. **217** PRIMARY REG. DIST. NO. **3045** Registrar's No. **76**

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Mississippi | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Mississippi | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston (Rural) 0670 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION West Commerical St. | | d. STREET ADDRESS (If rural, give location) Route 3, Box 159 | |

| | | | | |
|-------------------------------------|-------------------------|------------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Armie | b. (Middle) Lee | c. (Last) Martin | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1950 |
|-------------------------------------|-------------------------|------------------------|-------------------------|---|

| | | | | | | |
|----------------------|-------------------------------|---|--|--|---|---|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0 | 8. DATE OF BIRTH Sept. 26, 1947 | 9. AGE (In years last birthday) 2 | IF UNDER 1 YEAR Months 11 Days 29 | IF UNDER 24 HRS. Hours 0 Min. 0 |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Charleston, Missouri 0 | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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|---------------------------------------|---|-----------------------------------|
| 13a. FATHER'S NAME Gray Martin | 13b. MOTHER'S MAIDEN NAME Christine Holmes | 14. NAME OF HUSBAND OR WIFE _____ |
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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 Armour Holmes, R. 3, Box 159, Charleston, Mo. | ADDRESS _____ |
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| | | | |
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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 5 days |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | U9DX | |

| | | |
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| 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) |
|--|--|---|

| | | |
|--|---|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 24 1950 11:30 a.m. | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" 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 23, 1950** to **Sept 24, 1950**, that I last saw the deceased alive on **Sept 24, 1950**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

| | | |
|---|---|---------------------------------|
| 23. SIGNATURE W. D. Sparks (Degree or title) D.D. | 23b. ADDRESS W. D. Sparks, Charleston, Mo. | 23c. DATE SIGNED 9/26/50 |
|---|---|---------------------------------|

| | | | |
|---|---------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Sept. 26, 1950 | 24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | 24d. LOCATION (City, town, or county) (State) Charleston, Mo. |
|---|---------------------------------|--|--|

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|--|--|-----|--|--------------------------------|
| DATE REC'D BY LOCAL REG. Oct. 3, 1950 | REGISTRAR'S SIGNATURE Mrs. Lee Lige | 439 | 25. FUNERAL DIRECTOR'S SIGNATURE W. D. Sparks | ADDRESS Charleston, Mo. |
|--|--|-----|--|--------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 9 RECEIVED

RECEIVED

Miss. Co. Health D

County File No. _____

Date Filed NOV 1 0 19

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 Frank J. Sparks

Licensed Embalmer No. 3858

P. O. Address 212 E. Broadway

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.

W. H. G. B. F.