

FILED NOV 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36368**

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 362

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau
c. LENGTH OF STAY (In this place) 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cape Osteopathic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Missouri b. COUNTY Cape Girardeau
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pocahontas 0160
d. STREET ADDRESS (If rural, give location) Street not numbered

3. NAME OF DECEASED (Type or Print) a. (First) THEODORE b. (Middle) - c. (Last) MARTIN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1950

5. SEX Male 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 8. DATE OF BIRTH June 25, 1874 9. AGE (In years last birthday) 76 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) French Mo 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George Martin 13b. MOTHER'S MAIDEN NAME Lavinia Nations 14. NAME OF HUSBAND OR WIFE never married

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or title of service) Spanish American 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Leo Wilson Jackson R#1 ADDRESS _____

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.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Depression
ANTECEDENT CAUSES
MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.
DUE TO (b) Lobar Pneumonia
DUE TO (c) Surgical Removal of Gallbladder + Appendix
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis, heart atherosclerosis & mild myocardial changes

INTERVAL BETWEEN ONSET AND DEATH 585X

19a. DATE OF OPERATION Nov 15, 1950 19b. MAJOR FINDINGS OF OPERATION Cholecystitis and Incidental Appendix 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Nov 7, 1950, to Nov 19, 1950, that I last saw the deceased alive on Nov 19, 1950, and that death occurred at 2:32p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. Maxwell 23b. ADDRESS D.O. 2, 105 S. Spanish Cape Girardeau, Mo. 23c. DATE SIGNED Nov. 25, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Nov. 21, 1950 24c. NAME OF CEMETERY OR CREMATORY Apple Creek Cemetery 24d. LOCATION (City, town, or county) (State) Pocahontas Mo.

DATE REC'D BY LOCAL REG. 11-25-1950 REGISTRAR'S SIGNATURE C. C. Summers 44 25. FUNERAL DIRECTOR'S SIGNATURE W. Miller ADDRESS Jackson Mo.

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

0160

MAR 12 1951
MAR 12 1951

RECEIVED

NOV 27 1950

DISTRICT HEALTH OFFICE No. 6

File No.

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 Gene C. Crawford

Licensed Embalmer No. 4329

P. O. Address Jackson, 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.