

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40528

State File No.

FILED JAN 2 1950

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>174</u>		
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>				
b. CITY OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place) <u>7 yrs</u>		c. CITY OR TOWN <u>Nelson Valley Mo</u>		d. STREET ADDRESS <input checked="" type="checkbox"/> (If rural, give location) <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Nazan</u>								
3. NAME OF DECEASED a. (First) <u>George</u> b. (Middle) <u>A.</u> c. (Last) <u>Martin</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-20-50</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>1-17-1873</u>		
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u>		IF UNDER 1 MRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>unk</u>			13b. MOTHER'S MAIDEN NAME <u>unk</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME _____ 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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> 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. <u>4222</u>				
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 <u>11-18, 1950</u> to <u>11-20, 1950</u> , that I last saw the deceased alive on <u>11-20, 1950</u> , and that death occurred <u>2.45</u> mi., from the causes and on the date stated above.								
23a. SIGNATURE <u>Dr. Callihan M.D.</u> (Degree or title)				23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>11-27-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B-5</u>		24b. DATE <u>11-27-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Buffalo Mo</u>		24d. LOCATION (City, town, or county) (State) _____		
DATE REC'D BY LOCAL REG. <u>12-20-50</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robertson</u> ADDRESS <u>West Plains Mo</u>				

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

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DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED DEC 27 1950

Dist. File 1250-2574

Date Filed 12-27-50

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.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.