

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10305**

FILED MAR 29 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2442**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Frankfort 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 1002 E. Poplar avenue	
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL	b. (Middle) R.	c. (Last) MARTIN	4. DATE OF DEATH (Month) (Day) (Year) 3 12 52
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 6-29-1904
9. AGE (In years last birthday) 47		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman	10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (State or foreign country) West Frankfort, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Sherman Martin	13b. MOTHER'S MAIDEN NAME Catherine Hirks	14. NAME OF HUSBAND OR WIFE Fleta 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. 343-07-7462	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fleta Martin, West Frankfort, Ill.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) NEW MYOCARDIAL INFARCT ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) TWO PREVIOUS CORONARY THROMBOSES 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 checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from 2/23 , 19 52 , to 3/12 , 19 52 , that I last saw the deceased alive on 3/12 , 19 52 , and that death occurred at 10:00A m., from the causes and on the date stated above.			
23a. SIGNATURE JR Bradley	(Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 3/12/52
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 3-13-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) West Frankfort, Ill.
DATE REC'D BY LOCAL REG. MAR 14 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stone F. H., West Frankfort, Ill.	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ronald A. Yahn

Licensed Embalmer No. 29877

P. O. Address St. Louis

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.