

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28088

FILED AUG 24 1953  
BIRTH NO. 50451 REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 72

02510

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

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CLINTON</u>	
b. CITY OR TOWN <u>Cameron</u>	c. LENGTH OF STAY (In this place) <u>7m.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cameron</u> <u>0251</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cameron Hosp.</u>		d. STREET ADDRESS (If rural, give location) <u>Cameron Hosp.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby (Jean Lee)</u>	b. (Middle) <u>Martin</u>	c. (Last) <u>Martin</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 9 53</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Aug 8-53</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Cameron (Hosp) Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>Billy Dean Martin</u>	13b. MOTHER'S MAIDEN NAME <u>Lucie Brassfield</u>	14. NAME OF HUSBAND OR WIFE <u>—</u>
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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) <u>—</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Billy Dean Martin</u>	ADDRESS <u>—</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Birth</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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>776X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 8-8- 1953, to 8-9- 1953 that I last saw the deceased alive on 8-9- 1953, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>Dr. Cameron Mo</u>	23b. ADDRESS <u>—</u>	23c. DATE SIGNED <u>8-14-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug 9.53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>First Home</u>	24d. LOCATION (City, town, or county) (State) <u>— Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-20-53</u>	REGISTRAR'S SIGNATURE <u>Winifred W. Moser</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>—</u>
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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 Robert F. O'Connell

Licensed Embalmer No. 47774

P. O. Address 528 [unclear] St

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.