

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33686**
8660

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Cumberland	
b. CITY OR TOWN St. Louis, Mo.		c. CITY OR TOWN Casey	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) _____		e. STREET ADDRESS (If rural, give location) 8720 S	

3. NAME OF DECEASED (Type or Print)	a. (First) Roy	b. (Middle) Forest	c. (Last) Martin	4. DATE OF DEATH (Month) (Day) (Year)
				9 4 53

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 25. 1917	9. AGE (In years last birthday) 36	10. IF UNDER 1 YEAR Months _____	11. IF UNDER 1 YEAR Days _____	12. IF UNDER 1 YEAR Hours _____	13. IF UNDER 1 YEAR Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	----------------------------------	--------------------------------	---------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker	10b. KIND OF BUSINESS OR INDUSTRY Boilermaking.	11. BIRTHPLACE (City and State or Foreign Country) Jasper County Ill	12. CITIZEN OF WHAT COUNTRY? _____
---	--	---	------------------------------------

13a. FATHER'S NAME Lawrence Martin	13b. MOTHER'S MAIDEN NAME Flossie Huddleston	14. NAME OF HUSBAND OR WIFE Belle 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. Unknown	17. INFORMANT'S SIGNATURE OR NAME Belle Martin	ADDRESS Casey Illinois
--	--	---	-------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 Months
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphoscarcoma with metastasis to stomach	ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	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. Infarction to lower right lung		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 200.1	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) _____	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 **8/15**, 19**53**, to **9/4**, 19**53**, that I last saw the deceased alive on **9/4**, 19**53**, and that death occurred at **1:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE F. R. Smalley (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 9/4/53
---	-------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-6-53	24c. NAME OF CEMETERY OR CREMATORY Bethel	24d. LOCATION (City, town, or county) (State) Jasper County Ill.
--	-------------------------	--	---

DATE REC'D BY LOCAL REG SEP 5 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Hiles-Greenup ADDRESS Illinois
---	---	---

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.....
Signature of Student Embalmer

Signed No embalm *Cancelled* fact above

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.