

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1955

State File No. **24085**  
1003  
Registrar's No. **5475**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>1 Hour</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		STREET ADDRESS (If rural, give location) <b>24 3701a Pennsylvania 22497</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>FREIDA</b>	b. (Middle) <b>RUBY</b>	c. (Last) <b>MARTIN</b>	(Month) <b>June</b>	(Day) <b>21</b>	(Year) <b>1955</b>

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-22-1897</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
-------------------------	----------------------------------	--	--------------------------------------	--	---------------------------	--------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
--	--	--	--	---	--	---	--

13a. FATHER'S NAME <b>John Carlson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary McBride</b>		14. NAME OF HUSBAND OR WIFE <b>Leon H. Martin</b>	
---	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-05-2566</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Leon Martin, 3701a Pennsylvania</b>			
---	---	---	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Coronary Thrombosis</b>			
*This does not mean the mode of dying, such as heart failure, asthenia, 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.					

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? <b>4201</b>
--	--	---

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **7:35P m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Stuck L Taylor Coroner</i>	(Degree or title)	23b. ADDRESS <b>Bro. Clark</b>	23c. DATE SIGNED <b>6/24/55</b>
---	-------------------	-----------------------------------	------------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-24-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
--	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <b>JUN 24 1955</b>	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin F.H., Inc., 2301 Lafayette</b>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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 *A. G. Farris*.....

Licensed Embalmer No. *23*.....

P. O. Address *A. L.*.....

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.