

FILED MAY 10 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

13399

1708

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City	c. LENGTH OF STAY (In this place) 75 yrs	c. CITY OR TOWN Kansas City	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 General Hospital No. 1		e. STREET ADDRESS (If rural, give location) 5331 Highland	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Isabelle	b. (Middle)	c. (Last) Martin	Month 4	Day 18	Year 1956

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 16, 1876	9. AGE (In years last birthday) 79 years	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Fitzpatrick	13b. MOTHER'S MAIDEN NAME No record	14. NAME OF HUSBAND OR WIFE James Martin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Katherine Blake ADDRESS 416 East 26th Ave.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION K.C. North, Mo.		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction	DUE TO (b) _____		
*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 (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 April 17, 1956, to April 18, 1956, that I last saw the deceased alive on April 18, 1956, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns (Degree or title) M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 4-19-1956
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 21, 1956	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) K.C. Mo.
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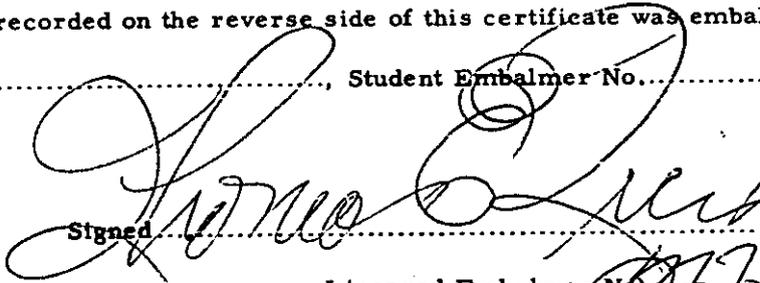
DATE REC'D BY LOCAL REG. 4-19-56	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE Thos. E. Quirk ADDRESS 4316 Troost Ave. K.C. Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 

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.