

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25128**
6478

FILED JUL 20 1956

318

1003

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		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 MISSOURI b. COUNTY _____			
b. CITY OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN ST. LOUIS		d. STREET ADDRESS (If rural, give location) 12 4963rd FOUNTAIN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARY INFIRMARY							
3. NAME OF DECEASED a. (First) LAURA (Type or Print)		b. (Middle) B		c. (Last) MARTIN		4. DATE OF DEATH (Month) (Day) (Year) 7-9-56	
5. SEX FEMALE		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Dec. 3, 1890	
9. AGE (In years last birthday) 65		# UNDER 1 YEAR Days 7		# UNDER 1 Mts. Hours 6			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ABRAHAM KEMP		13b. MOTHER'S MAIDEN NAME EMMA JENKIN		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Bianca Thomas ADDRESS 4963 Fountain			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) none DUE TO (c) none II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		3314		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		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) _____ m.		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 7-6 , 19 56 , to 7-9 , 19 56 , that I last saw the deceased alive on 7-9 , 19 56 , and that death occurred at 10:42 m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Blair Moore M.D.				23b. ADDRESS 4501 A Sester		23c. DATE SIGNED 7-11-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 7-10-56		24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEM.		24d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MD	
DATE REC'D BY LOCAL REG. JUL 11 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.F. WALTON 2707 STODDARD ST			

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.