

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19913**

FILED JUN 24 1957

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 228

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville	
d. FULL NAME OF HOSPITAL OR INSTITUTION 405 W. Michigan		d. STREET ADDRESS (If rural, give location) 405 W. Michigan	

3. NAME OF DECEASED (Type or Print)	a. (First) Cora	b. (Middle) Effie	c. (Last) Martin	4. DATE OF DEATH (Month) (Day) (Year) June 17, 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 15, 1886	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Farm home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George Hopper	13b. MOTHER'S MAIDEN NAME Robha Etta Hall	14. NAME OF HUSBAND OR WIFE Sion Martin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Don't know	17. INFORMANT'S SIGNATURE OR NAME Sion Martin, Kirkville, Mo.	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Coronary artery disease		
	DUE TO (c) Coronary arteriosclerosis		
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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 5-29, 1957, to 6-16, 1957, that I last saw the deceased alive on 6/16, 1957, and that death occurred at 1:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Milou Locke, D.O. (Degree or title) 2	23b. ADDRESS Kirkville Osteopathic Hosp. Kirkville, Mo.	23c. DATE SIGNED 6/19/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 20, 1957	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	24d. LOCATION (City, town, or county) (State) Sullivan Co., Mo.
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DATE REC'D BY LOCAL REG. 6-21-57	REGISTRAR'S SIGNATURE Doris W. Ratliff	25. FUNERAL DIRECTOR'S SIGNATURE Glenn E. Fent & Son	ADDRESS Brem City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

535

SUN 26 1951

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

Karl R. Kent

Licensed Embalmer No. *4689*

P. O. Address *Green City, Mo.*

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.