

FILED SEP 9 1957

## STANDARD CERTIFICATE OF DEATH

'57 0 27 668

STATE FILE NUMBER

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 215

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Callaway</b>                                                                                                                                                                                                                                                                                                             |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>                        |                                                                                                                                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Fulton</b>                                                                                                                                                                                                                                                                      |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                               | c. CITY OR TOWN <b>Fulton</b><br>0140<br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                    |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Callaway Hospital</b>                                                                                                                                                                                                                                                       |                                  | Length of stay in 1b <b>5 1/2 Days</b>                                                                                                                             | d. STREET ADDRESS <b>R.F.D. # 4</b><br>(If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Laura</b> Middle <b>Alverta</b> Last <b>Martin</b>                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                                    | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>6</b> Year <b>1957</b>                                                                             |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept-22-1883</b><br>73                                                                                                    |
| 9. AGE (In years last birthday)<br><b>73</b>                                                                                                                                                                                                                                                                                                               |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                          | IF UNDER 24 HRS.                                                                                                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                                                                   | 11. BIRTHPLACE (City and state or country)<br><b>Callaway Co, Mo.</b>                                                                            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                              |                                  | 13. FATHER'S NAME<br><b>Thomas W. Kemp</b>                                                                                                                         |                                                                                                                                                  |
| 14. MOTHER'S MAIDEN NAME<br><b>Annie Galwith</b>                                                                                                                                                                                                                                                                                                           |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>                                            |                                                                                                                                                  |
| 16. SOCIAL SECURITY NO.<br><b>482-26-3857</b>                                                                                                                                                                                                                                                                                                              |                                  | 17. INFORMANT<br>Address<br><b>Mrs. Ralph Basinger Fulton, Mo R#4</b>                                                                                              |                                                                                                                                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Hypertensive arteriosclerosis C-V</b><br>DUE TO (c) <b>myocardial infarction</b> |                                  |                                                                                                                                                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>15</b>                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>443X</b>                                                                                                                                                                                                           |                                  |                                                                                                                                                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                |
| 20a. ACCIDENT <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>                                                                                                                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                     |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.                                                                                                                                                                                                                                                                                                |                                  |                                                                                                                                                                    |                                                                                                                                                  |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                                                          | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                                                                                                        |
| 21. I attended the deceased from <b>1946</b> to <b>6 Sept 57</b> and last saw <u>her</u> alive on <b>6 Sept 57</b><br>Death occurred at <b>1:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                 |                                  |                                                                                                                                                                    |                                                                                                                                                  |
| 22a. SIGNATURE<br><b>E. R. Gish</b> (Degree or title)                                                                                                                                                                                                                                                                                                      |                                  | 22b. ADDRESS<br><b>Fulton Mo</b>                                                                                                                                   | 22c. DATE SIGNED<br><b>7 Sept 57</b>                                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                 | 23b. DATE<br><b>Sept 8, 1957</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carrington Cemetery</b>                                                                                                   | 23d. LOCATION (City, town, or county) (State)<br><b>Carrington Mo</b>                                                                            |
| 24. FUNERAL DIRECTOR<br><b>Shallace Funeral Home</b>                                                                                                                                                                                                                                                                                                       |                                  | ADDRESS<br><b>Fulton Mo</b>                                                                                                                                        | 25. DATE RECD. BY LOCAL REG.<br><b>Sept. 7-1957</b>                                                                                              |
| 26. REGISTRAR'S SIGNATURE<br><b>Maretha Lawrence</b>                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                                                                                    |                                                                                                                                                  |

with, officers, public service

00 56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

26-1)

(Licensed Embalmer's Statement on Reverse Side)

JAN 4 1963

MAR 13 1963

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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. Spector*.....

Licensed Embalmer No. *79*

P. O. Address *Fulton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING, 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.