

FILED SEP 24 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4178

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Peters	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Sedalia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. Hospital		d. STREET ADDRESS (If outside, give location) 306 E. Second Street	
3. NAME OF DECEASED (Type or print) First ORAN Middle A. Last MARTIN		4. DATE OF DEATH Month 9th Day 5th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired fireman		11. BIRTHPLACE (City and state or country) Sedalia, Mo.	
13a. FATHER'S NAME William B. Martin		14. NAME OF HUSBAND OR WIFE --- none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		17. INFORMANT Roy C. Martin Address 2001 Indeb. Ave. Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of Death Unknown		INTERVAL BETWEEN ONSET AND DEATH 7955	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Based on operating ablt. procedure		19. WAS AUTOPSY PERFORMED? 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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from September 5, 1957 to September 5, 1957 Death occurred at 3:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22b. ADDRESS 1034 Fifth Blvd	
22a. SIGNATURE (Degree or title) Hugh H. Owens ³		22c. DATE SIGNED 9-6-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-6-57	
23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery		23d. LOCATION (City, town, or county) (State) Sedalia, Mo.	
24. FUNERAL DIRECTOR Marion Young ADDRESS Sedalia, Mo.		25. DATE RECD. BY LOCAL REG. 9-6-57	
		26. REGISTRAR'S SIGNATURE Neva Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Hugh H. Owens

All diseases in Part I must be causally related.

SEP 24 1957

OCT 17 1957

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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 *Rhona Ewing*.....

Licensed Embalmer No. *3647*.....

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.