

Dept. Health,  
& Welfare  
S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39307

STATE FILE NUMBER  
1263

FILED NOV 25 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth Hosp.</u>		Length of stay in 1b <u>Life</u>	d. STREET ADDRESS <u>705 1/2 So. 17th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>GRACE</u> Last <u>MARTIN</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1895</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Scott City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Edward Corder</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. Emma Terry</u>		14. NAME OF HUSBAND OR WIFE <u>Eddie Martin (de)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Katherine Hinkle, St. Joe</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause lost. } DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post operative gastrectomy</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>5-10-54</u> to <u>11-15-57</u> and last saw her alive on <u>11-14-57</u> Death occurred at <u>3:50</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Chas W. Schaefer MD</u> (Degree or title)			22b. ADDRESS <u>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>11-18-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Nov 18, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u>
24. FUNERAL DIRECTOR <u>John E. Kuepp</u> ADDRESS <u>6054 Pryor</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 21, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

USE ONLY BLACK INK-OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

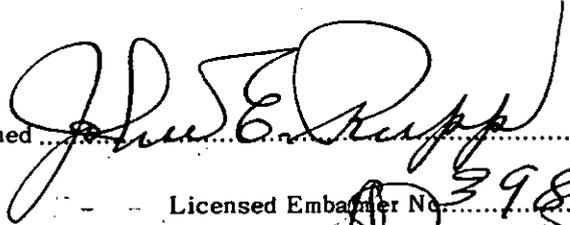
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(Licensed Embalmer's Statement on Reverse Side)

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. 3986 .....

P. O. Address St. Joseph .....

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.