

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027660
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1858

5. 300
7. 1-57

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Lemay 23		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hospital		Length of stay in lb D.O.A.	d. STREET ADDRESS (If outside, give location) 730 Bartolet		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Earl Middle None Last Martin			4. DATE OF DEATH Month July Day 11 Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1902	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service station		10b. KIND OF BUSINESS OR INDUSTRY self-employed	11. BIRTHPLACE (City and state or country) Sikeston, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Alfred B. Martin		13b. MOTHER'S MAIDEN NAME Nancy Ann Flynn.		14. NAME OF HUSBAND OR WIFE Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 466093232		17. INFORMANT Address Elizabeth Martin, 730 Bartolet	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis.				INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4201					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Bronchial Asthma.				19. WAS AUTOPSY PERFORMED? 2 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 _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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 July 7, 57 to July 11, 58 and last saw him alive on July 9, 1958 Death occurred at _____ on the date stated above; and to the best of my knowledge, from the cause(s) stated.					
22a. SIGNATURE (Degree or title) Ray C. Ruppel M.D.			22b. ADDRESS 7722 Perry Ave		22c. DATE SIGNED 7/12/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7-14-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) Lemay 23, Mo.
24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co., 7420 Michigan (11)			25. DATE RECD. BY LOCAL REG. 7-14-58	26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	

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.

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 *W E Morris*

Licensed Embalmer No. *3360*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

(If not for use, return to the State Board of Health, St. Louis, Mo.)