

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035046
STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2528

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE, (Where deceased lived. If in institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Berkeley</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richmond Heights</u> 4495 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>903 Foxwell St. one week</u>		Length of stay in 1b <u>one week</u>	d. STREET ADDRESS (If outside, give location) <u>1030 Commodore Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lora</u> Middle <u>a</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1st.</u> Year <u>1958</u>			
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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>April 8, 1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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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>Fulton Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u></u>
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13a. FATHER'S NAME <u>Robert W. Thomason</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Ida Berlin</u>	14. NAME OF HUSBAND OR WIFE <u>Earl W. Martin</u>
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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. Pearl S. Patrick 1030 Commodore Drive</u>
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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>uronia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Artero-sclerosis</u>	
	DUE TO (c) <u>Cardio-vascular Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>		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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Fulton Missouri</u>	COUNTY <u></u> STATE <u></u>
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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 <u>Fulton Missouri</u>	COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>1-9-50</u> to <u>9-30-58</u> and last saw her alive on <u>9-30-58</u> Death occurred at <u>903 Foxwell Ave</u> , <u>7:40 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Colon P. Hales M.D.</u> (Degree or title)	22b. ADDRESS <u>6826 Natural Bridge</u>	22c. DATE SIGNED <u>10/1/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 2nd 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>	23d. LOCATION (City, town, or county) <u>Fulton Missouri</u>
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24. FUNERAL DIRECTOR <u>Bull-Campbell Directory 5165 Delmar</u>	ADDRESS <u></u>	25. DATE RECEIVED BY LOCAL REG. <u>10-1-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u>
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(License of Registrar's Statement on Reverse Side)

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Elton R. Remelus*

Licensed Embalmer No. *4283*
P. O. Address *St. Louis*

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.