Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004969
STATE FILE NUMBER

FILED MAR 3 1959 Registration District No. 93 Primary Registration District No. Registrar's No. 59-16

1. PLACE OF DEATH
a. COUNTY: Dade
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Greenfield Mo — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Home — Length of stay in 1b: yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY: Dade
c. CITY OR TOWN: Greenfield Mo. — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Wells St — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Leulla Last: Martin
4. DATE OF DEATH: Month Feb Day 15 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 16 1878
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 11 Days 29 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Cooper Co Mo
12. CITIZEN OF WHAT COUNTRY? usa
13a. FATHER'S NAME: Myr Martin
13b. MOTHER'S MAIDEN NAME: Cynthia Bailey
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Inez Cowden Address: Bolivar Mo.

MEDICAL CERTIFICATION

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: 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis — 6 months
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 3-25-58, to 2-9-59 and last saw her alive on 2-9-59
Death occurred at 3:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Lee A. McNeel Jr. MD
22b. ADDRESS: Greenfield, Mo.
22c. DATE SIGNED: 2-24-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb 17 1959
23c. NAME OF CEMETERY OR CREMATORY: Greenwood
23d. LOCATION (City, town, or county) (State): Bolivar Mo.
24. FUNERAL DIRECTOR: W.R. Allison ADDRESS: Greenfield Mo
25. DATE RECD. BY LOCAL REG.: 2/26/1959
26. REGISTRAR'S SIGNATURE: J. C. Canada
(Licensed Embalmer's Statement on Reverse Side)

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.

Lee A. McNeel, Jr. M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed W. R. Allison .....
Signature of Student Embalmer

Licensed Embalmer No. 4404
P. O. Address Greenfield

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.