

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008500
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 312

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in 1b 8 days	d. STREET ADDRESS (If outside, give location) 2904 Sherman Ave.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Gretta Williams Martin			4. DATE OF DEATH Month Day Year March 24, 1959		
---	--	--	--	--	--

5. SEX Female	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 July 23, 1879	9. AGE (In years last birthday) 79	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Washington, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	--	-------------------------------------

13a. FATHER'S NAME John S. Williams	13b. MOTHER'S MAIDEN NAME Martha Malin	14. NAME OF HUSBAND OR WIFE Augustus A. Martin
--	---	---

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. None	17. INFORMANT Augustus S. Martin, St. Joseph, Missouri	Address 2904 Sherman Ave
--	---------------------------------	---	--------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
DUE TO (b) <i>renal failure</i>		
DUE TO (c) <i>arteriosclerotic heart disease & auricular fibrillation</i>		<i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <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 <i>9/15/58</i> to <i>3/24/59</i> and last saw ^{her} alive on <i>3/23/59</i> Death occurred at <i>12:15A</i> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Donald J. Stallard, M.D.</i> (Degree or title)	22b. ADDRESS <i>902 Edmund St.</i>	22c. DATE SIGNED <i>3/24/59</i>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>3/27/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive St.</i>	23d. LOCATION (City, town, or county) (State) <i>Troy, Kansas</i>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <i>Heaton-Bowman</i> Heaton-Bowman, St. Joseph, Missouri	25. DATE RECD. BY LOCAL REG. <i>Mar. 26, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Stallard</i>
---	--	--

All diseases in Part I must be causally related.

Dr. Donald J. Stallard
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 Eugene Wood

Licensed Embalmer No. 3804
P. O. Address 319 So. 10th St. Joplin

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.