

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-030624**

**SEP 4 1959**

**2 7802**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis,</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis,</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2806 So. 59th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>W.</u> Last <u>MARTENS, JR.</u>			<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>21,</u> Year <u>1959</u>		
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<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-3-1932</u>	<b>9. AGE (last birthday)</b> <u>26</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Material Planner</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>McDonnell Aircraft</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>William W. Martens, Sr.</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Dorothea Lohman</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Helen Martens</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>491-34-1318</u>	<b>17. INFORMANT</b> <u>Helen Martens-2806 S. 59th Str.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic reticulum cell sarcoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Reticulum cell sarcoma</u> DUE TO (c) <u>200.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>13 months</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____
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<b>21. I attended the deceased from</b> <u>7/18/59</u> , to <u>8/21/59</u> and last saw <u>him</u> alive on <u>8/21/59 @ 7 AM</u> . Death occurred at <u>9:45 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22a. SIGNATURE</b> (Deceased or title) <u>Keith E. Pipes M.D.</u>	<b>22b. ADDRESS</b> <u>3701 Grandel Square St. Louis</u>	<b>22c. DATE SIGNED</b> <u>8/21/59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>	<b>23b. DATE</b> <u>Aug. 24, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New St Marcus</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Kriegshauser-4228 S. Kingshighway</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>AUG 24 '59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Keon Smith, M.D.</u>
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BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Stoverland

Licensed Embalmer No. 1007

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.