

FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030626

FILED VS. SEP 11 1959

2 7905

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 2 Days	c. CITY OR TOWN MT. VERNON Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2227 Casey Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN SAMUEL MARTIN			4. DATE OF DEATH Month Day Year AUGUST 25 1959			
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 3-6-1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL		11. BIRTHPLACE (City and state or country) GOLDEN GATE, ILL.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Joseph MARTIN		13b. MOTHER'S MAIDEN NAME LUCRETIA -		14. NAME OF HUSBAND OR WIFE NANCY MARTIN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Nancy Martin Address MT. VERNON, ILL.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: OIL Joseph M. Martin IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to above cause (b) DUE TO (b) CORONARY THROMBOSIS Joseph M. Martin DUE TO (c) CORONARY ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 96 HOURS 96 HOURS UNKNOWN
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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) LEFT CEREBROVASCULAR ACCIDENT. INTERSTITIAL PNEUMONIA		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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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) FELL OFF ROOF OF GARAGE WHILE PAINTING HOUSE.	
20c. TIME OF INJURY Hour 4:30 Min. 30 Month, Day, Year 8/20/59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	20f. CITY, TOWN, OR LOCATION COUNTY STATE MT. VERNON ILLINOIS

21. I attended the deceased from **AUGUST 23, 1959** to **AUGUST 25, 1959** and last saw her/him alive on **AUGUST 25, 1959**
Death occurred at **9:07 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Martin M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 8/25/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-26-59	23c. NAME OF CEMETERY OR CREMATORY OAK Wood Cem.	23d. LOCATION (City, town, or county) (State) MT. VERNON ILL.	
24. FUNERAL DIRECTOR MYERS ADDRESS MT. VERNON, ILL		25. DATE RECD. BY LOCAL REG. AUG 26 '59	26. REGISTRAR'S SIGNATURE Loan Smith. M. D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Frank Proff

Licensed Embalmer No. 4356

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.