

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032025

FILED VS OCT 5 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1006

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in 1b <u>40 yrs.</u> | c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>1645 E. Grand</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1645 E. Grand</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>S.</u> Last <u>Martin</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 13, 1878</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinery maintenance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Car Company</u> | | 11. BIRTHPLACE (City and state or country) <u>Peabody, Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME <u>Robert S. Martin</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Stackhouse</u> | | 14. NAME OF HUSBAND OR WIFE <u>Lola M. Martin</u> | |
| 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>UNKNOWN</u> | | 17. INFORMANT Address <u>Lola M. Martin-Springfield, Mo.</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>Arteriosclerosis, gen'd</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sev. yrs</u> | | |
| 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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|---|---|--|------------------------------|--------|-------|
| 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.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 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 1950 to 9-22-59 and last saw him ^{her} alive on 9-22-59
Death occurred at _____ h. _____ m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>G. L. Lemmon, Jr. M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Springfield, Mo.</u> | | 22c. DATE SIGNED <u>9-23-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept 26, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u> | 23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo</u> | |

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| 24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey-Springfield, Missouri.</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-28-59</u> | 26. REGISTRAR'S SIGNATURE <u>Effie E. Mellon</u> |
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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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Ray J. [Signature]*
Licensed Embalmer No. 3812

P. O. Address Springfield,

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.