

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035002

FILED VS. SEP 25 1959 **366**

71

STATE FILE NUMBER

ENDED

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Belgrade</b> Length of stay in 1b <b>life</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>12 mi. W of Belgrade</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN <b>Belgrade</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>12 mi. W of Belgrade</b> Residence on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>LOUISA JANE MARTIN</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>Sept. 12 1959</b>				
<b>5. SEX</b> <b>fem</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-1-68</b>	<b>9. AGE (last birthday)</b> <b>91</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Washington Co. Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>John McCain</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mahalia Yount</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Wallace Martin</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> Address <b>Mrs. Hallie Ramsey, Caledonia Mo.</b>			
<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) <b>APOPLEXY</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>HYPERTENSION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
<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.)	
<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"/> <b>NOT WHILE AT WORK</b> <input checked="" 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					
<b>21. I attended the deceased from</b> <b>Sept. 11, 1959</b> to <b>Sept. 12, 1959</b> and last saw her <u>her</u> alive on <b>Sept. 12, 1959</b> Death occurred at <b>7-35 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Edward Lake, MD</b>				<b>22b. ADDRESS</b> <b>Potosi, Missouri</b>		<b>22c. DATE SIGNED</b> <b>Sept. 15, 1959</b> (State)	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>23b. DATE</b> <b>9-15-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Antioch Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Quaker, Missouri.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>White Funeral Home, Ironton Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>9/19/59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Helmut Rudal</b>		

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 *Amel J. White*

Licensed Embalmer No. 3012

P. O. Address *Smith Ave*

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.