

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037253

FILED VS NOV 10 1959

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 139

ENDED

1. PLACE OF DEATH a. COUNTY <u>RAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>RAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND Juss</u>		c. CITY OR TOWN <u>RICHMOND</u>	
Length of stay in 1b <u>9 hrs.</u>		inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RAY COUNTY MEM. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>VIRGINIA</u> Last <u>MARTENS</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>22</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 22 1959</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HR Hours <u>9</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>RAY COUNTY, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	

13a. FATHER'S NAME <u>LEE ROY MARTENS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY RUTH FERGUSON</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>LEE ROY MARTENS - Richmond, Mo.</u>	
(If yes, give war or dates of service)		Address			

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>Respiratory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congenital Atelectasis</u>			
DUE TO (c) <u>Prematurity</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 <u>7:05</u> a.m. / p.m.	Month, Day, Year <u>10-22-59</u>		
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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 10-22-1959 to 10-22-59 and last saw her 10-22-59 alive on 10-22-59.
Death occurred at 10-22-59 7:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Do not print)		22b. ADDRESS <u>Wollington, Mo.</u>		22c. DATE SIGNED <u>10-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRHAVEN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>NORBORNE, Mo.</u>	

24. FUNERAL DIRECTOR <u>KNIPSCHILD + BORCHERTING - HARDING</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-5-1959</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 August Bouchard

Licensed Embalmer No. 4678

P. O. Address Hardin, 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.