

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

**FILED VS NOV 3 1959**

**59-037856**

STATE FILE NUMBER

**2 9698**

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

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b <b>25 Yrs.</b>	c. CITY OR TOWN <b>St. Louis,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3836 Blaine</b>		d. STREET ADDRESS <b>3836 Blaine</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>EMMA ELIZABETH MARTIN</b>	<b>4. DATE OF DEATH</b> Month Day Year <b>Oct. 21, 1959</b>
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<b>5. SEX</b> <b>Female</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>9/13/77</b>	<b>9. AGE</b> (last birthday) <b>82</b>	<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) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Unk. Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>E. Lee</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Darby</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>William (Dec.)</b>
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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) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>No</b>	<b>17. INFORMANT</b> Address <b>Paul Martin, Cairo, Ill.</b>
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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) <b>Acute myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>present 10-15-59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cardio-Renal-Vascular disease &amp; hypertension</b>	
	DUE TO (c) <b>442x</b>	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <b>Cerebral hemorrhage 7-3-58</b>	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input checked="" 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
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <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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**21. I attended the deceased from** **11-14-39** to **10-20-59** and last saw her/him alive on **10-15-59**  
Death occurred at **1:00 pm 10-20-59** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <b>John T Flynn BMD</b>	<b>22b. ADDRESS</b> <b>1716 So. 39th St. Louis, MO</b>	<b>22c. DATE SIGNED</b> <b>10-22-59</b>
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<b>23a. BURIAL, CREMATION, OR OTHER DISPOSITION</b> <b>Removal</b>	<b>23b. DATE</b> <b>10-23-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Maynard</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Dienststadt, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>McLaughlin, 2301 Lafayette St. Louis, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 23 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Roan Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

*m85*

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

*James R. Chapman*  
\_\_\_\_\_  
Licensed Embalmer No. 45  
P. O. Address St. Louis

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.