

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
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U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN - 7 1959 2
 Registration District No. _____ Primary Registration District No. 5019 Registrar's No. 69
 '59 0 4 3224
 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ANDREW				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ANDREW									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROCHESTER TOWNSHIP		Length of stay in 1b		c. CITY OR TOWN NODAWAY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION SHADY LAWN			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JOHN Middle MARTIE Last				4. DATE OF DEATH Month December Day 24 Year 1959									
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-5-74		9. AGE (last birthday) 85		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) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (City and state or country) Andrew County, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Christian Martie				13b. MOTHER'S MAIDEN NAME Magaline Baughman				14. NAME OF HUSBAND OR WIFE Lulu Martie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. - - -		17. INFORMANT Address Mrs. Carl Patterson, Nodaway, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the stomach with obstructive symptoms and hemorrhage. 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 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senile Psychoses.								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					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 10-30-53 to 12-24-59 and last saw him alive on 12-21-59 Death occurred at 7:40 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <i>William Baker M.D.</i>				22b. ADDRESS Savannah, Missouri		22c. DATE SIGNED 12-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12-27-59		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City, town, or county) (State) Amazonia, Missouri							
24. FUNERAL DIRECTOR ADDRESS BREIT & HAWKINS SAVANNAH			25. DATE RECD. BY LOCAL REG. 12-28-59		26. REGISTRAR'S SIGNATURE <i>Killian Sparks</i>								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 8

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 Jamell B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Seward

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.