

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003783

EILED VS FEB 5 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 588** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>4 Mo's.</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>City Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>6146 Plymouth Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL RAYMOND MARTIN</b>				4. DATE OF DEATH Month Day Year <b>Jan. 17, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 25/09 50</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Doss Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Walter Martin</b>			13b. MOTHER'S MAIDEN NAME <b>Adeline McCarter</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 2 497-07-2957</b>		17. INFORMANT Address <b>St. Ann Mo.</b> <b>Lorene Hunter 10221 St. Daniel La.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus. extensive</b> <b>Brain damage to the left</b> <b>middle parietal.</b> DUE TO (b) <b>Hepatitis.</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suffered when</b>					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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (If in care of hospital, give name of hospital) <b>all 3435 Missarie Avenue</b>					
20c. TIME OF INJURY Hour a.m. p.m. <b>9 a.m.</b> Month, Day, Year <b>2/17/59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>24 Building</b>						
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY (TOWN, OR LOCATION)		COUNTY		STATE	
<b>24 Building</b>		<b>St Louis</b>		<b>Mo</b>			
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <b>1220 h</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree & Title) <b>Joseph M. Quinn</b>				22b. ADDRESS <b>1300 E. Cash</b>		22c. DATE SIGNED <b>1-18-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 20 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo.</b>			
24. FUNERAL DIRECTOR <b>Kellen Kelly</b>		ADDRESS <b>7267 Natural Bridge</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 18 1960</b>		26. REGISTRAR'S SIGNATURE <b>Lead Smith M.O.</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*James G. L...*

Licensed Embalmer No. 414

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.