

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014898

FILED VS. MAY 9 1960

128

Registration District No. 2000

Registrar's No. 498

STATE FILE NUMBER

DED

|   |  |   |  |   |   |  |   |       |
|---|--|---|--|---|---|--|---|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> |   |  |   |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>   |  | Length of stay in 1b<br><b>5 years</b>  |  | c. CITY OR TOWN <b>Springfield</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>645 S. Grant Avenue</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>645 S. Grant Avenue</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>OSCAR</b> Middle <b>EDWIN</b> Last <b>MARTIN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>28</b> , Year <b>1960</b>   |   |  |   |       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/6/1894</b>   | 9. AGE (last birthday)<br><b>66</b>   | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clergyman</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baptist Church</b>                           |   | 11. BIRTHPLACE (City and state or country)<br><b>Atkins, Arkansas</b>       |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |       |
| 13a. FATHER'S NAME<br><b>William Martin</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Dora Gillum</b>                                      |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>La Ura Martin</b>  |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |  | 16. SOCIAL SECURITY NO.<br><b>341-16-8949</b>   |  | 17. INFORMANT <b>Springfield, Missouri.</b><br><b>Mrs. La Ura Martin, 645 S. Grant,</b>   |   |  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>   |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                                     |       |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |   |   |  |   |       |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year _____  |  |   |   |  |   |       |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>6/22/59</b> to <b>4/28/60</b> and last saw her alive on <b>7/14/59</b><br>Death occurred at <b>4:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |   |       |
| 22a. SIGNATURE (Degree or title)<br><b>John A. Beckwith M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>Springfield Mo</b>   |   |  | 22c. DATE SIGNED<br><b>5/2/60</b>   |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>5/2/1960</b>           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>White Chapel</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Springfield, Missouri.</b>  |   |  |   |       |
| 24. FUNERAL DIRECTOR<br><b>Ralph Thieme, Springfield, Missouri</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-3-60</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Effie B. Meeton</b>                         |  |   |       |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 10 1960  
MAY 9 1960

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 Harold L. Fettes

Licensed Embalmer No. 507

P. O. Address Spfld, Ill

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.