

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 4 1960

-60-018132

INDEXED

Registration District No. 366 Primary Registration District No. _____ Registrar's No. 44

STATE FILE NUMBER

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Washington | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kingston Twp. | | c. CITY OR TOWN Kingston Twp. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt.1, Cadet, Mo. | | d. STREET ADDRESS (If outside, give location) Rt.1, Cadet, Mo. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | | |
|---|----------------------------------|---|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Rosa Middle Mae Last Martin | | | 4. DATE OF DEATH Month April Day 30 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/12/89 | 9. AGE (last birthday) 70 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Washington Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Timothy Yates | | 13b. MOTHER'S MAIDEN NAME Sarah Politte | | 14. NAME OF HUSBAND OR WIFE Charles Martin | | |
| 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. None | | 17. INFORMANT Address Charlene Graham, Rt.2, DeSoto, Mo. | | |

| | | | | |
|---|--|-----------------------------------|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| IMMEDIATE CAUSE (a) Cerebral | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Atherosclerosis | | |
| | | DUE TO (c) Hypertension | | |
| 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 |

| | | | | |
|--|---|--|--------|-------|
| 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 _____ 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 4-24-60 to 4-30-60 and last saw her alive on 4-30-60
Death occurred at 2:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--|----------------------------|---|---|
| 22a. SIGNATURE <i>C.E. Feine</i> | (Degree or title) | 22b. ADDRESS <i>S.O. 105 DeSoto Mo</i> | 22c. DATE SIGNED 4-30-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/2/60 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | 23d. LOCATION (City, town, or county) DeSoto, Mo. |

| | | | |
|--|------------------------|--|--|
| 24. FUNERAL DIRECTOR J. Lee Mothershead, Mo. | ADDRESS DeSoto, | 25. DATE REC'D. BY LOCAL REG. 5/2/60 | 26. REGISTRAR'S SIGNATURE <i>Robert Kudal</i> |
|--|------------------------|--|--|

(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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. Lee Mathershead

Licensed Embalmer No. 3531

P. O. Address De Soto, W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.