

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029481

FILED VS AUG 24 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3600 Registrar's No. 247

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Schyler</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville</u>		Length of stay in 1b		c. CITY OR TOWN <u>Lancaster</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim-Smith Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Belle</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-9-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Schyler County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>America</u>	
13a. FATHER'S NAME <u>William Nelson</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Kerines</u>			14. NAME OF HUSBAND OR WIFE <u>Edward (NPN) Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Hospital Record Kirkville, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <u>7-31-60</u> to <u>8-17-60</u> and last saw her ^{her} _{him} alive on <u>8-16-60</u> Death occurred at <u>4:10</u> <u>4</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Kirkville, Mo.</u>		22c. DATE SIGNED <u>8-17-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arni Memorial Cemetery Lancaster, Mo.</u>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR <u>Norman Funeral Home Lancaster, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>8-18-1960</u>	26. REGISTRAR'S SIGNATURE <u>Dora W. Ratliff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. B. Jones, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ of by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Keokuk, Iowa

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.