URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-033470
STATE FILE NUMBER

NDED

FILED MS SEP 12 1960 Registration District No. 325 Primary Registration District No. 4480 Registrar's No. 83

1. PLACE OF DEATH
a. COUNTY: SCHUYLER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: GREENTOP
Length of stay in 1b: 2 MO.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: GREENTOP NURSING HOME
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: SCHUYLER
c. CITY OR TOWN: LANCASTER
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): NONE
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle (.ONE) Last MARTIN

4. DATE OF DEATH: Month SEPT. Day 2, Year 1960

5. SEX	6. COLOR OR RACE	7.	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
MALE	WHITE	Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	9-3-1871	88	11	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
FARMER	FARMING	SCHUYLER COUNTY	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
WILSON B. MARTIN	VITULA C. STEWART	ELSIE MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	VERTA LYONS, LANCASTER, MO.,

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	Cerebral Thrombus	10 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerosis Obliterans	2 yrs.
DUE TO (c)	Generalized Arteriosclerosis	10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Gangrene of feet

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7/24/60 to 9/2/60 and last saw ~~her~~ him alive on 9/2/60
Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Edward M. Roberts, M.D.
22b. ADDRESS: Queen City, Mo.
22c. DATE SIGNED: 9/6/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	9-5-1960	ARNI MEMORIAL CEMETERY	LANCASTER, MISSOURI

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
MORMAN FUNERAL HOME, LANCASTER, MO.,	9.5.60	Mrs. O. J. Drake

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Jno E Foster

Licensed Embalmer No. 4742

P. O. Address Fukuoka,

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