

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035736

FILED VS. OCT 5 1960 278

3054 Registrar's No. 120

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Pike</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Pike</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		Length of stay in 1b <b>25 Da.</b>		c. CITY OR TOWN <b>Louisiana</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>PIKE CO HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Jackson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Martin</b> Last				4. DATE OF DEATH Month <b>Sept</b> Day <b>27</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/1884</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (City and state or country) <b>Pike Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Will Martin</b>			13b. MOTHER'S MAIDEN NAME <b>Lizzie Yocum</b>			14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>330-05-1176</b>		17. INFORMANT Address <b>George Martin, Frankford Mo</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>Congestive Circulatory Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Decompensated Hypertensive Heart Disease</b>							<b>Unknown</b>	
DUE TO (c) <b>Advanced Arteriosclerosis</b>							<b>Unknown</b>	
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 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>6-29-60</b> to <b>9-27-60</b> and last saw him alive on <b>9-27-60</b> Death occurred at <b>11:03 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Roy Y. Broderson M.D.</b>				22b. ADDRESS <b>218 North 5th St Louisiana Mo.</b>			22c. DATE SIGNED <b>9-30-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/30/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) <b>Louisiana Mo.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Sterne Funeral Home Louisiana Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 3-1960</b>		26. REGISTRAR'S SIGNATURE <b>Bernice Calhoun</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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OCT 10 1960

**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. B. Stene

Licensed Embalmer No. 4039  
 P. O. Address Louisiana

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