

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041127

FILED VS NOV 28 1960

042

Primary Registration District No. 1000

Registrar's No. 1208

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in lb <i>77 years</i>	c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>607 N. 10th Street</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>607 N. 10th Street</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>COLLEEN MARGARITE MARTIN</i>			4. DATE OF DEATH Month Day Year <i>November 19 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>May 9, 1929</i>	9. AGE (last birthday) <i>31</i>	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Child Monitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Child care</i>		11. BIRTHPLACE (City and state or country) <i>Wichita, Kansas</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>Isador Martin</i>		13b. MOTHER'S MAIDEN NAME <i>Nellie Ferguson</i>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Nellie Blizzard</i>			Address <i>Elwood, Kansas</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Over dose of Placidil</i>					<i>1 hour</i>	
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. <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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Self administered</i>				
20c. TIME OF INJURY Hour <i>8</i> a.m. Month, Day, Year <i>11-19-60</i>	Home	607 N 10 St Joseph Buchanan MO				
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 <i>brewed body 8 am</i> and last saw her <i>alive on Nov 20-60</i> Death occurred at <i>8 am</i> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>J. E. Melaney M.D.</i>			22b. ADDRESS <i>14 W. Park Street St Joseph Mo</i>		22c. DATE SIGNED <i>11-20-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 26, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>			
24. FUNERAL DIRECTOR <i>Clark Funeral Home</i>		ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Nov. 22, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Seadell</i>		

DOCUMENT

S.F. Melaney M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 9 NOV

**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 Ernest Wood

Licensed Embalmer No. 5864

P. O. Address 319 So 10th St

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.