MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-015427
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3518

FILED APR 24 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 2 Wks.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: De Paul Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Ferguson
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 216 Wesley Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: E. Last: MARTIN
4. DATE OF DEATH: Month Day Year: 4-11-61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-22-12
9. AGE (last birthday): 48
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): Physician
10b. KIND OF BUSINESS OR INDUSTRY: Medicial
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Dr. Charles P. Martin
13b. MOTHER'S MAIDEN NAME: Lydia Ellerbrock
14. NAME OF HUSBAND OR WIFE: Marjorie Williamson Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Marjorie Martin Ferguson, Address: Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive heart disease and — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Polycystic kidneys
DUE TO (c): 443.1
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. ☐ 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 1956, to 1961 and last saw her/him alive on 4-10-61
Death occurred at 7:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title): MD
22b. ADDRESS: 372 W Washington
22c. DATE SIGNED: 4-12-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-13-61
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: White-Mullen Mortuary 118 N. Florissant Rd.
25. DATE RECD. BY LOCAL REG.: APR 12 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Reinhold K Lohrmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35

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.