

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-018113**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 42

**FILED MAY 29 1961**

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>68 Yr.</u>	c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N. 25th. St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>N. 25th. St.</u>		
3. NAME OF DECEASED (Type or print) First <u>EDMUND</u> Middle <u>ELISHA</u> Last <u>MARTIN</u>			4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</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>APR 19, 1893</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (specify if raised)) <u>Hod Carrier (Brick)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Lexington, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Brad Martin</u>		13b. MOTHER'S MAIDEN NAME <u>Lizzie Kirkman</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Warren</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W. I</u>			17. INFORMANT Address <u>Mrs. Bertha Martin Lex., Mo.</u>			
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 <u>2 days</u>	
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>				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 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>5-8-61</u> to <u>5/9/61</u> and last saw <sup>her</sup> him alive on <u>5-9-61</u> . Death occurred at <u>12:30</u> p. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Deed or title) <u>[Signature]</u>			22b. ADDRESS <u>Wellington, Mo</u>		22c. DATE SIGNED <u>5-12-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lexington,</u>	(State) <u>Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Vaughn-Walker Lexington, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-12-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1961 9 NNC

MAY 29 1961

JUN 9 1961

**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

*Harold L. Walker*

Licensed Embalmer No. 45-88

P. O. Address Lehigh Co., Pa.

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.