

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030097

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 301

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED SEP 15 1961

1. PLACE OF DEATH
 a. COUNTY **Marion**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Hannibal** Length of stay in 1b **35 yrs.**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Elizabeth Hospital** Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri** COUNTY **Marion**
 c. CITY OR TOWN **Hannibal** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **420 Munger St.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
THEODORE M. MARTIN **9 - 5 - 61**
 5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **1-4-73** 9. AGE (last birthday) **88** IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.
 10a. USUAL OCCUPATION (Give kind of work done during year, even if retired) **Blacksmith** 10b. KIND OF BUSINESS OR INDUSTRY **Own** 11. BIRTHPLACE (City and state or country) **Adair Co., Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Warrnie Martin** 13b. MOTHER'S MAIDEN NAME **Louisa Jane Ross** 14. NAME OF HUSBAND OR WIFE **Orga Martin**
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT Address **Hannibal, Mo.**
Mrs. Orga Martin, 420 Munger

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Arteriosclerotic heart disease, cardiac decompensation** INTERVAL BETWEEN ONSET AND DEATH **5 days**
 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)
 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 Month, Day, Year
 a.m. p.m.

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
9/1/61 10:10A. 9/5/61 and last saw her him alive on 9/5/61

21. I attended the deceased from **9/1/61 10:10A.** and last saw her him alive on **9/5/61**
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
 22a. SIGNATURE (Degree or title) 22b. ADDRESS 22c. DATE SIGNED
[Signature] **Hannibal Mo.** **Sept 6/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)
Burial 9/7/61 Grandview Burial Pk. Hannibal, Mo.
 24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE
Jack Schwartz, Hannibal, Mo. 9/6/61 St. E.D. Lusche by William M. Herman

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 Jack Schwartz
Licensed Embalmer No. 4900

P. O. Address Harrisburg, 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.