

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-033320

STATE FILE NUMBER

Registration District No. 15<sup>th</sup> Primary Registration District No. 3127 Registrar's No. 150

AMENDED

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>		Length of stay in 1b. <b>lifetime</b>	c. CITY OR TOWN <b>Webb City</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>DOA Jane Chinn Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1129 W. Nelson St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print): First <b>Melveta</b> Middle <b>E.</b> Last <b>Martin</b>			4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-1934</b>	9. AGE (last birthday) <b>26</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Webb City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Otho Martin</b>		13b. MOTHER'S MAIDEN NAME <b>Bess M. Wells</b>		14. NAME OF HUSBAND OR WIFE	
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.	17. INFORMANT <b>Mrs. Bess M. Martin</b> Address <b>1129 W. Nelson Webb City, 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>Acute Congestive Heart Failure</b> DUE TO (b) <b>Congenital Heart Deformity</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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 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>10-3-61</b> to <b>10-3-61</b> and last saw <del>her</del> <b>him</b> alive on <b>10-3-61</b> Death occurred at <b>7:45 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>D. O. Gregory</i>		(Degree or title) <b>D.O.</b>	22b. ADDRESS <b>Webb City, Mo.</b>		22c. DATE SIGNED <b>10-4-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-5-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carterville Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Carterville, Mo;</b>		
24. FUNERAL DIRECTOR <b>Johnston-Simpson, Webb City, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-5-61</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Madeline Switzer</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City

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.