

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Filed **149** **OCT 19 1961**

Primary Registration District No. **1002** Registrar's No. **5019**

61-037077
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 53 years	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 612 ROMANY ROAD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Laura MARTIN			4. DATE OF DEATH Month Day Year October 8, 1961
5. SEX Female	6. COLOR OR RACE Cauc.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH OCT. 17, 1866
9. AGE (last birthday) 94		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Miller County, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME George W. Hayes	
13b. MOTHER'S MAIDEN NAME Hester Ann Morse		14. NAME OF HUSBAND OR WIFE JAMES B. MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. J. HAROLD SHEEHAN 612 ROMANY
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Thrombosis DUE TO (b) Arteriosclerotic vas. disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3wk
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 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 Month, Day, Year a.m. p.m.			
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 Sept. 1957 to 10-8-61 and last saw her alive on 10-8-61 Death occurred at 3:10 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John B. Justina M.D. (Degree or title)		22b. ADDRESS 4620 Nichols Pkwy E.C. MO	22c. DATE SIGNED 10-8-61
23a. BURIAL, CREATION, REMOVAL (Specify) Burial	23b. DATE OCTOBER 11, 1961	23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY	23d. LOCATION (City, town, or county) (State) Independence Missouri
24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6500 TROOST	25. DATE RECD. BY LOCAL REG. 10-9-61	26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF
John B. Justina M.D.

ITEM NO. SHOULD READ

Dr. John Justice -
4620 S. C. Nichols
Je 1-1500

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

R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address

K. C. Nichols

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.