

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039795

STATE FILE NUMBER

Registration District No. 335 Primary Registration District No. 4480 Registrar's No. 28

AMENDED

FILED OCT 23 1961

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Schuyler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greentop Mo</u>		Length of stay in 1b <u>2Yrs</u>	c. CITY OR TOWN <u>Glenwood Mo</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>Greentop Nursing home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CLARINDA</u> Middle <u>NONE</u> Last <u>MARTIN</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>15</u> , Year <u>1961</u>		
5. SEX <u>Female</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>6/17/1868</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Chariton County, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Cornelius Morford</u>		13b. MOTHER'S MAIDEN NAME <u>Pernicia Toney</u>		14. NAME OF HUSBAND OR WIFE <u>Harry Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Leoard Martin</u> Address <u>Glenwood, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute Toxicity</u>	
	DUE TO (c) <u>Bronchial pneumonia</u>	

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	
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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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		

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 <u> </u> COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>Oct '59</u> to <u>Oct '61</u> and last saw her/him alive on <u>10-13-61</u> Death occurred at <u>12:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Frank Trisk D.D.</u>		22b. ADDRESS <u>PO Box 235 Greentop, Mo</u>	22c. DATE SIGNED <u>10-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/17/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Glenwood, Missouri</u>

24. FUNERAL DIRECTOR <u>Norman Funeral Home, Lancaster, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 17, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Florence Shepherd</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
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 Nova E Foster

Licensed Embalmer No. 4742

P. O. Address Kennel

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.