SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-043372

STATE FILE NUMBER

AMENDED

Registration District No. 32-5 Primary Registration District No. 45-20 Registrar's No. 5

FILED NOV 30 1961

1. PLACE OF DEATH
a. COUNTY Texas

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Howell

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | Length of stay in 1b

c. CITY OR TOWN Mtn. View | Inside Limits Yes ☐ No ☒

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home | Inside Limits Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location) Rural Route 1 | Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: William Middle: Riley Last: Martin

4. DATE OF DEATH Month: October Day: 31 Year: 1961

5. SEX M

6. COLOR OR RACE W

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4/14/67

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) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Sullivan, Mo.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Caferie Martin

13b. MOTHER'S MAIDEN NAME Mary Jane Boster

14. NAME OF HUSBAND OR WIFE Martha J. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address: Luther Martin Rt. 1 Mtn. View, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic Pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Congestive Heart Failure

DUE TO (c)

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. ☐ 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 a.m. p.m. Month, Day, Year

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

21. I attended the deceased from 1960, to Oct. 31, 1961 and last saw her/him alive on Oct. 31, 1961

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) Stanley Barnum D.O.

22b. ADDRESS Mtn. View, Missouri

22c. DATE SIGNED 11/7/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11/2/1961

23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery

23d. LOCATION (City, town, or county) (State) Mtn. View, Missouri

24. FUNERAL DIRECTOR ADDRESS Duncan Funeral Home Mtn. View, Mo.

25. DATE RECD. BY LOCAL REG. 11-25-61

26. REGISTRAR'S SIGNATURE Julia Powell

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | DOCUMENT | SHOULD READ | ITEM NO. | 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_____ Signed Charles D. Partain

Signature of Student Embalmer

Licensed Embalmer No. 5107

P. O. Address Mtn. View

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.