

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-004187
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **516**

AMENDED

FILED JAN 19 1962

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

| | | | | | | |
|---|--|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | | | | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4452 Maffitt | | d. STREET ADDRESS (If outside, give location) 4452 Maffitt | | | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Dixie Middle Martin Last | | | 4. DATE OF DEATH Month 1 Day 9 Year 62 | | | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) About 65 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sod Carrier | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state of country) Trillin, Ark. | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Grant Martin | | 13b. MOTHER'S MAIDEN NAME Henrietta Franklin | | 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) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address Ella Wallace-4333 St. Louis | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) |
| DUE TO (c) 4430 | | | | | | |
| 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 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 8-3-1961 to 1/9/62 and last saw her/him alive on 1/9/62 | | Death occurred at 10:00 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |
| 22a. SIGNATURE (Degree or title) Deputy C. K. ... | | | 22b. ADDRESS 1423 No. ... | | 22c. DATE SIGNED 1/11/62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 1-15-62 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood | | 23d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS A.L. Beal Und.Co.-4303 Delmar | | | 25. DATE RECD. BY LOCAL REG. JAN 12 1962 | | 26. REGISTRAR'S SIGNATURE Roal Smith, M.D. | |

SECRET

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 Arthur L. Halliard

Licensed Embalmer No. 4221

P. O. Address 3100 Eastona

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.

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