

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED OCT 13 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31879

State File No. ....

Registration District No. 3.22

Primary Registration District No. 3071

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location) none  
(d) Length of stay: In hospital or institution 8 yrs (Specify whether years, months or days)  
In this community

3. (a) PRINT FULL NAME Martha Susan Hulien

3. (b) If veteran, no name war no  
3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife dead 6. (c) Age of husband or wife if alive 13 years  
7. Birth date of deceased June, 1854  
(Month) (Day) (Year)

8. AGE: Years 90 Months 3 Days 4 If less than one day  
hr. min.

9. Birthplace Monroe Co. U Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

12. Name James Dry  
13. Birthplace U Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Brown  
15. Birthplace U Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E. R. Davenport  
(b) Address Slater, Mo.

17. (a) burial (b) Date thereof 9-19-'44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Centralia, Mo.

(c) Place: burial or cremation Hill Brothers  
(d) Signature of funeral director Slater, Mo.  
(b) Address

19. (a) Oct 4-1944 (b) Mrs. John G. Giger  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline  
(c) City or town Slater  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16  
year 1944 hour 6.45 minute P M.

21. I hereby certify that I attended the deceased from Dec 1942 to Sept-17-1944  
that I last saw him alive on Sept-17-1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Diabetic Coma Duration 2 weeks

Due to  
Due to

Other conditions Hemiparesis right leg  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature M. E. Duggins (M. D. or other)  
Address Slater, Mo. Date signed 9/18/44

DISTRICT HEALTH COMMISSION  
District File Number \_\_\_\_\_  
Date Filed 10-11-44

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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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

*Sam M. Hill*

Licensed Embalmer No. \_\_\_\_\_

*1292*

P. O. Address \_\_\_\_\_

*St. Louis Mo*

**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 this body is not embalmed, fact should be so stated above.**