

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township 1st Primary Registration District No. 1002
 City Wagon (No. 4900 S. Benton)

File No. **32947**
 Registered No. 4175
 St. _____ Ward _____

2. FULL NAME

Cyrus Lee Martin
 (a) Residence, No. 4900 S. Benton St. 16 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella May Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 30 - 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 4 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Self
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

10. NAME OF FATHER

Eli Martin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

12. MAIDEN NAME OF MOTHER

Frances

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

14. INFORMANT

(Address) Robert Martin
4900 S. Benton

15. FILED

10/14, 1930 m. m. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Oct 14, 1930 that I last saw him alive on 10 - 14 - 1930, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enemic coma
139
1356
13213 (duration) 2 mos. 4 da.
 CONTRIBUTORY (SECONDARY) Prostate hypertrophy & retention of urine (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. A. Singer, M. D.

10/14, 1930 (Address) 4375 Pacific Ave.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Raymore Mo. Oct 16 1930

20. UNDERTAKER

ADDRESS

Mr. C. L. Foster KCMo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. J. J. Jones