

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

Do not use this space.

39423

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. Stockyards-16th Avenue)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4495
St. _____ Ward)

2. FULL NAME

Arthur Oliver Martin

(a) Residence No. 7136 Summit St., 3 Ward.

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Ina F. Martin

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Don't know

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

abt 45

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer)

Stock yards Co

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas

10. NAME OF FATHER

John Martin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14. INFORMANT

(Address)

Ina F. Martin
7136 Summit

15. FILED

12/15 1930

M. M. Brown

Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-9 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart attack stroke
HTA
ISC

CONTRIBUTORY (SECONDARY)

Patrol Wagon (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS _____

17 (Signed) Harvey M. Hill M. D.

19, 1930 (Address) Republic Iron

*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

Memorial Park 12/13 1930

20. UNDERTAKER

ADDRESS

Carson & Son Independence
711

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.

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