

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
In this community Unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 558 Main St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME CHARLES MARTIN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex male 5. Color or race White (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 30 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 5 If less than one day
hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Edward Martin
13. Birthplace France
14. Maiden name Elizabeth Clements
15. Birthplace S.C.
(City, town, or county) (State or foreign country)

16. (a) Informant Special Clerk
(b) Address K.C. Gen. Hosp.

17. (a) Removal (b) Date thereof 12-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Wailert Funeral Home
(b) Address 2332 Monitor Place, K. C. Mo.

19. (a) 12-20-40 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th
year 1940 hour 10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 10-30-40, 19____, to 11-5-40, 19____;
that I last saw him alive on 11-5-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate
Duration _____

Due to 51
Due to _____

Other conditions _____
(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? 361
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Henry R. Stone (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Blaine E. Weibull

Licensed Embalmer No. *4075*

P. O. Address *2332 Monitor Place*

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, above space should be left blank.