V. S. No. 2
OM—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23495

FILED JUL 27 1942

Registration District No. 299

Primary Registration District No. 10

Registrar's No. 2743

48
3
8

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
513 N Warner /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 3 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City, Mo. 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 513 N Warner
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Elbert Martin

3. (b) If veteran, name war -- no

3. (c) Social Security No. none

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced -- 0

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased April 15, 1942
(Month) (Day) (Year)

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

9. Birthplace Kansas City, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business --

FATHER
12. Name Worth E. Martin
13. Birthplace Okla. /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Norah Parker
15. Birthplace Okla. /
(City, town, or county) (State or foreign country)

16. (a) Informant Worth E. Martin
(b) Address 513 N. Warner, K.C.Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-18-42
(Month) (Day) (Year)
(c) Place: burial or cremation Tulsa, Okla.

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave. K.C.Mo.

19. (a) 7/18/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18th
year 1942 hour 7 minute 10 A M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Due to Thymus - 64

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy Thymus & hymphoid hyperplasia

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

23. Signature [signature] (M. D. or other)
Address [signature] Date signed 7/6/42

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(Licensed Embalmer's Statement on Reverse Side)

24 in Tall Weight 16 lbs. Blue Eyes

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.....

Licensed Embalmer No.....

P. O. Address.....

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.