S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 16 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10780

Registration District No. 336 Primary Registration District No. 6137 Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

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

(c) Name of hospital or institution: Rural Ninona Twp (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon

(c) City or town Rural Ninona Twp (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

3. (a) PRINT FULL NAME Andrew J. Martin

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

4. Sex M D 5. Color or race A 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rhoda E. Martin 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Apr (Month) 18 (Day) 1867 (Year)

8. AGE: Years 77 Months 10 Days 5 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name David Martin
13. Birthplace (City, town, or county) Georgia (State or foreign country)

MOTHER
14. Maiden name Sara Jane Adams
15. Birthplace (City, town, or county) Georgia (State or foreign country)

16. (a) Informant John D Martin
(b) Address Eminence Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb (Month) 28 (Day) 1945 (Year)
(c) Place: burial or cremation Ninona Mo

18. (a) Signature of funeral director Luckel
(b) Address Van Buren Mo

19. (a) 2-24-44 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23 year 1945 hour minute 30 M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on Feb 25 , 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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 Frank Hyde O (M. D. or other)

Address Eminence Mo Date signed 2-28-45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 945/52
Date Filed 3-15-48

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.