

S. No. 2
M-243
5-17-39
P-I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23098

State File No. 2986
Registrar's No.

FILED JUL 30 1945

Registration District No. 167 Primary Registration District No. 1002

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

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:
McMahon Nursing Home 623 Euclid 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 Years
(Specify whether years, months or days)

In this community Unknown

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. 623 Euclid
(If rural, give location)

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

3. (a) PRINT FULL NAME William Martin

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80	Unknown		
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hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name: Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant McMahon Nursing Home

(b) Address 623 Euclid K.C. Mo.

17. (a) Removal (b) Date thereof July 17, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation H.C. Western Dental College

18. (a) Signature of funeral director Collins Funeral Home

(b) Address 1110.3 W. 11th St. Independence Mo.

19. (a) 7-17-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1945 hour 13 minute 05 A.M.

21. I hereby certify that I attended the deceased from June 1945, to July 16 1945;

that I last saw him alive on July 15 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis and myocardial degeneration

Due to

Duration 9 yrs.

Other conditions Arterio-sclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations 93 X

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?

(e) Means of injury 2

23. Signature C. Blain Richter (M. D. or other) D.O.

Address 724 1/2 Prospect Date signed 7-16-45

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.