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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

10316

FILED

MAR 27 1946
273

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 5915

Registrar's No. 17

1. PLACE OF DEATH

(a) County Perry
(b) City or town Rural Central Perry
(c) Name of hospital or institution: Perryville, R. 4, 1
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Perry
(c) City or town Rural
(d) Street No. R. 4, D. #4
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME August Martens
3. (b) If veteran, name war _____
3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19th
year 1946 hour 3:00 minute 00 P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Caroline Hooy 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased September 18, 1872
(Month) (Day) (Year)

Immediate cause of death Cardiac failure

8. AGE: Years 73 Months 5 Days 1 If less than one day _____ hr. _____ min.

Due to _____
Due to _____

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

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

10. Usual occupation Retired farmer

Major findings: _____
Of operations _____

11. Industry or business _____
12. Name Engelbert Martens
13. Birthplace Belgium
(City, town, or county) (State or foreign country)
14. Maiden name Barbara Ber
15. Birthplace Belgium
(City, town, or county) (State or foreign country)

Of autopsy _____
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Natural
(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?
While at work? _____ (Specify type of place)
(e) Means of injury 2

16. (a) Informant Leo Martens
(b) Address Perryville, Mo.

23. Signature CM Weedman (M. D. or other) DO
Address Perryville, Mo Date signed _____

17. (a) Burial (b) Date thereof 2-22-1946
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial St. Boniface Cemetery

18. (a) Signature of funeral director Ben Thomas Stone
(b) Address Perryville, Mo.

19. (a) Feb 20, 1946 (Date received local registrar) Joe Joellner (Registrar's signature)

250

(Licensed Embalmer's Statement on Reverse Side) CORNER OF PERRY CO

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

MOTHER FATHER

4.2
-m2
4
246-1890
3-25-40

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..... *Albert Ben*

Licensed Embalmer No..... *3866*

P. O. Address..... *Perryville, Pa*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

April

Registration District No.

273

Primary Registration District No.

5915-

Registrar's No.

17

1. PLACE OF DEATH:

(a) County Permy
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME

August M antenna

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 15 (Month) (Day) (Year)8. AGE: Years 73 Months 5 Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 9 Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to myo Cardial DegenerationDue to ArteriosclerosisOther conditions _____
 (Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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? _____

While at work _____ (Specify type of place)

(e) Means of injury 223. Signature W. Weidman (M. D. or other)Address Permyville, mo Date signed 4/5/46

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

9236

SUPPLEMENTARY

10316

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