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DEPARTMENT OF HEALTH
STATE OF MISSOURI
FILED MAR 1947

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **9259**
Registrar's No. **961**

Registration District No. **149** 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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 DAYS**
(Specify whether 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. **1308 E. 16TH ST.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **ANNA MARTIN**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. **NO**
 4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **Sol Martin** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **FEBRUARY** day **27**, year **1947** hour **8:** minute **15 P.** M.
 21. I hereby certify that I attended the deceased from **FEBRUARY 15**, 19 **47** to **FEBRUARY 27**, 19 **47**.
 That I last saw h. **ER** alive on **FEBRUARY 27**, 19 **47**.
 and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT**
 Duration _____
 Due to **HYPERTENSIVE HEART DISEASE**

8. AGE: Years Months Days If less than one day
ABOUT 90 _____ hr. _____ min.

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

9. Birthplace **LITTLE ROCK** **ARKANSAS**
(City, town, or county) (State or foreign country)

Major findings: **93 d**
 Of operations _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

10. Usual occupation **At Home**

11. Industry or business
12. Name **JOHN MOORE**
13. Birthplace **ARKANSAS**
(City, town, or county) (State or foreign country)
14. Maiden name **MARTHA**
15. Birthplace **ARKANSAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **VELMA MUNDY (GRAND-DAUGHTER)**
 (b) Address **1910 TROOST**
17. (a) Burial (b) Date thereof **3/4/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Lincoln cemetery**

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)
 (c) Means of injury _____

18. (a) Signature of funeral director **Watkins Bros.**
 (b) Address **1729 Wyden Ave.**
19. (a) 3-3-47 (b) **Seraldine Holman**
(Date received local registrar) (Registrar's signature)

23. Signature **E. Frank Selin** (M. D. or other) **MD.**
 Address **GENERAL HOSPITAL NO. 2** Date signed **2/28/47**

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.....

Bruce Riley....., Registered Apprentice No. *1183*
working under my personal supervision.

Signed.....
J. J. McAuliffe

Licensed Embalmer No. *3994*

P. O. Address *2000 Highland*

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.