

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

**FILED MAY 5 1947**

Registration District No. 1997

Primary Registration District No. 1002

Registrar's No. 1826

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:  
1223 Bales 1  
(If not in hospital or institution, write street number or location)

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

In this community 2 1/2 years  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 1223 Bales  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Morris Milton Martin Sr.

3. (b) If veteran, name war no

3. (c) Social Security No. 486-01-0778

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Sarah Martin 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 19 1873  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 20 year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1946 to April 20 1947  
that I last saw him alive on April 19 1947 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>1</u>	<u>1</u>	hr. min.

Immediate cause of death Acute myocardial degeneration

Due to Chronic Myocarditis 3 yrs

Due to \_\_\_\_\_

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

Other conditions 93.D.  
(Include pregnancy within 3 months of death)

10. Usual occupation Businessman

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Fredrick Martin

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

14. Maiden name don't know

15. Birthplace don't know  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant John F. Martin

(b) Address 417 E. 10th KC Mo.

17. (a) Burial (b) Date thereof 4-23-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Federal Hill Cem.

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? \_\_\_\_\_

18. (a) Signature of funeral director Mrs. E. J. Forster

(b) Address 9-18 Brooklyn

19. (a) 4-22-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury 2

23. Signature E. J. Forster (M. D. or other)

Address 3309 E. 12 Date signed 4-24-47

Dr. Reese  
3307 E 12th  
K. 12411  
3 Pm

MAY 10 1958

**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..... *Dean Owens* .....

Licensed Embalmer No. *4289*  
*918 Brooklyn*  
P. O. Address..... *K. C., Mo.* .....

**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.**