

Registration District No. 1947 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:  
General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 mos. 13 days  
(Specify whether  
 In this community 12 years  
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. Little Sisters of Poor  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Joseph Martin  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh  
 6. (a) ~~Single~~, widowed, ~~married~~, divorced 2  
 6. (b) Name of husband or wife unknown  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov 14 1864  
(Month) (Day) (Year)

**8. AGE:**  
 Years 82 Months 6 Days 7  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name Anthony Martin 9  
 13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Estrella Rims 9  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Little Sisters of the Poor  
 (b) Address 533 Highland  
 17. (a) Burial (b) Date thereof 5-24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St Marys

18. (a) Signature of funeral director Mark A. Gobin  
 (b) Address 2000  
 19. (a) 5-23-47 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month May day 21  
 year 1947 hour 6 minute 55 P. M.

21. I hereby certify that I attended the deceased from Jan. 8 1947 to May 21 1947  
 that I last saw him alive on May 21 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations 93.2  
 Of autopsy None

**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? 0

23. Signature Tom W. Hart (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp Date signed 5-22-47  
(Specify type of place) (c) Means of injury

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

*Handwritten notes and scribbles in the top right corner.*

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**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, \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address WCMO

**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.**