

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31899**
Registrar's No. **4294**

No. 300
10.48
FILED SEP 24 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (In this place) 30 YRS		d. STREET ADDRESS (If rural, give location) 1705 WABASH	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL # 2		3258	

3. NAME OF DECEASED (Type or Print) a. (First) IDA b. (Middle) MARTIN c. (Last) MARTIN			4. DATE OF DEATH (Month) (Day) (Year) AUGUST. 30, 1953		
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 5-12-1870	9. AGE (In years) (last birthday) 83	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME DAVE HICKMAN	13b. MOTHER'S MAIDEN NAME PENNY Mc MILLIAN WILLIAM	14. NAME OF HUSBAND OR WIFE WILLIAM MARTIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MINNIE DALE 1705 WABASH - K.C., MO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 420
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY CONGESTION		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-25, 1953, to 8-30, 1953, that I last saw the deceased alive on 20, 1953, and that death occurred at 8:00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. Frank Ellis MD	23b. ADDRESS 600 E. 22nd. St.	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE SEP. 1, 1953	24c. NAME OF CEMETERY OR CREMATORY BLUE RIDGE LAWN	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
DATE REC'D BY LOCAL REG. 9-1-53	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE BRADY-BROWN	ADDRESS K.C., MO.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John R. Edmon

Licensed Embalmer No. 4531

P. O. Address Kansas City, 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.

WRITE PLAINLY—USING UNFADING INK

case, injury, or complication which caused death.		DUE TO (6)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>14 Sept</u> , 19 <u>53</u> , to <u>26 Sept</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>26 Sept</u> , 19 <u>53</u> , and that death occurred at <u>5:50 Pm.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
<u>John H. Mayer Jr. M.D.</u>		<u>618 Prof Bldg KC Mo</u>		<u>9/29/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)		
<u>removal</u>	<u>9/26/53</u>	<u>Blakely Cemetery</u>	<u>Dedrick, Mo.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
			<u>Eichinger Funeral Home, Nevada, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

1953 S-31899

Signed

Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address Indep. 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.