

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8815**  
**1117**

BIRTH NO. FILED **MAR 31 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (In this place) <b>33 yrs.</b>		Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lakeside Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>24 2629 Elmwood 3348</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MARY</b>	b. (Middle) <b>Molly</b>	c. (Last) <b>MARTIN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>March-10-1954</b>
-------------------------------------	------------------------	--------------------------	-------------------------	--

5. SEX <b>Female</b>	6. COLOR OF RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 30-1890</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>-</b>	IF UNDER 30 DAYS Days <b>-</b>	IF UNDER 24 HOURS Hours <b>-</b>	IF UNDER 60 MIN. Min. <b>-</b>
----------------------	-------------------------------	---	--------------------------------------	---	---------------------------------	--------------------------------	----------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Carrollton, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	--	--	--

13a. FATHER'S NAME <b>Eisenhour</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Pleasant Martin</b>
-------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Frances Conley</b> ADDRESS <b>2629 Elmwood, W. C. Mo.</b>
--	-------------------------------	---

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Apoplexy</b>		<b>3 days</b>
	DUE TO (c) <b>Hypertension</b>		<b>5 yrs.</b>
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)	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 **3-1**, 19**54**, to **3-10**, 19**54**, that I last saw the deceased alive on **3-10**, 19**54**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>Kenneth Adler</b> (Degree or title) <b>D.O.</b>	23b. ADDRESS <b>2646 Jackson K.C., Mo.</b>	23c. DATE SIGNED <b>3-12-54</b>
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>March-13-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Rak Hill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Carrollton, Missouri</b>
--	--------------------------------	---	---

DATE REC'D BY LOCAL REG. <b>3-12-54</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C.H. Blackman &amp; Son Inc.</b> ADDRESS <b>K.C., Mo.</b>
---	---	---

WRITE PLAINLY—USING 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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Bert B. Benn*

Licensed Embalmer No. *465*

P. O. Address *Hancock*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.