

FILED FEB 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2337**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **277** PRIMARY REG. DIST. NO. **44-11** Registrar's No. **7**

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

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bowling Green</b>	c. LENGTH OF STAY (in this place) <b>4 1/2 yrs</b>	c. CITY OR TOWN <b>BOWLING GREEN</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>HICKERSON REST HOME</b>		STREET ADDRESS (If rural, give location) <b>College Street</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>ELLA</b>	b. (Middle) <b>KATHERINE</b>	c. (Last) <b>MARTIN</b>	Date (Month) (Day) (Year)	<b>FEB</b>	<b>2 1956</b>

5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>FEB 10 1865</b>	9. AGE (In years last birthday) <b>90</b>	if UNDER 1 YEAR Months	if UNDER 1 YEAR Days	if UNDER 1 HRS. Hours	if UNDER 1 HRS. Min.
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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		11. BIRTHPLACE (City and State or Foreign Country) <b>FRANKFORD, Mo. (RURAL)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>JAMES L. MARTIN</b>	13b. MOTHER'S MAIDEN NAME <b>EMILY SHOTWELL</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mary Beat Frankford Mo.</b>		ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Insufficiency</b>	DUE TO (b) <b>Myocarditis</b>			3 days
ANTECEDENT CAUSES	DUE TO (c) <b>Arteriosclerosis</b>			yes
II. OTHER SIGNIFICANT CONDITIONS	<b>Carcinoma of Breast</b>			yes
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 **Feb 1, 1956** to **Feb 2, 1956**, that I last saw the deceased alive on **Feb 1, 1956** and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>M. Mathews M.D.</b>	23b. ADDRESS <b>Bowling Green Mo. 2-4-56</b>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>FEB 3 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>VANDALIA CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>VANDALIA MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>2-4-56</b>	REGISTRAR'S SIGNATURE <b>Bill Robinson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Fred M. Meador</b>	ADDRESS <b>Frankford Mo.</b>
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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, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lore Fields Megowan*.....  
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Licensed Embalmer No.....

P. O. Address *Frankford*.....

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.