

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2557-60-019513

ENDED

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>11 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>422 W 11th</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>422 W 11th</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED First WARREN Middle L Last MARTIN 4. DATE OF DEATH Month May Day 4 Year 1960

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 7-5-1904 9. AGE (last birthday) 55 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY L 11. BIRTHPLACE (City and state or country) Ky 12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME William Martin 13b. MOTHER'S MAIDEN NAME Iris Chabe 14. NAME OF HUSBAND OR WIFE Hellie Ruth Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) eyes (If yes, give year or dates of service) WW II 16. SOCIAL SECURITY NO. 81-20-428 17. INFORMANT Hellie Ruth Martin Address 422 W 11th

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Hugh H. Owens Coroner 22b. ADDRESS 1034 Pacific Bldg 22c. DATE SIGNED 5-5-60

23a. FUNERAL, CREATION, REMOVAL (Specify) Funeral 23b. DATE 5-10-60 23c. NAME OF CEMETERY OR CREMATORY Natl. Cemetery 23d. LOCATION (City, town, or county) (State) Jeffersonville Kans

24. FEDERAL DIRECTOR ADDRESS Street 25. DATE RECD. BY LOCAL REG. May 9 - 1960 26. REGISTRAR'S SIGNATURE Neva Minshall

DOCUMENT

BY AFFIDAVIT OF Hugh H. Owens MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Dennis B. Foxguth*

Licensed Embalmer No. 492

P. O. Address K C 20

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.