

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6505-61-044886 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1-002 Registrar's No. \_\_\_\_\_

FILED JAN 15 1962

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>1 Year</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kansas City T.B. Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9806 Roland</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Glyde</u> Middle <u>Meredith</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1961</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/21/98</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Brick Industry</u>	11. BIRTHPLACE (City and state or country) <u>Ashland Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Forest Martin</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <del>*****</del>
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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) <u>No</u>	17. INFORMANT <u>Tommy Green Lee's Summit Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u>		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Sept, 1961 to Dec, 23, 61 and last saw him alive on Dec, 23 1961  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.W. Buckingham</u> (Degree or title)	22b. ADDRESS <u>Professional Bldg, K.C. Mo.</u>	22c. DATE SIGNED <u>12/23/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 27, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvery Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
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24. FUNERAL DIRECTOR <u>Langford Funeral Home</u> <u>Lee's Summit Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
Buckingham MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

OFFICE OF THE STATE EMBALMER

MEMPHIS, TENNESSEE

1961

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

OFFICE OF THE STATE EMBALMER

MEMPHIS, TENNESSEE

1961

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

OFFICE OF THE STATE EMBALMER

**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 W.B. Langford

Licensed Embalmer No. 3233

P. O. Address Louis Dummett

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.