

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039357
STATE FILE NUMBER

FILED NOV 25 1958

Registration District No. 83

Primary Registration District No. 4145

Registrar's No. 13

1. PLACE OF DEATH a. COUNTY COOPER b. CITY OR TOWN PRAXIE HOME c. FULL NAME OF (If NOT in hospital, give location) PRAXIE HOME MO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY COOPER c. CITY OR TOWN PRAXIE HOME MO d. STREET ADDRESS PRAXIE HOME MO	
3. NAME OF DECEASED (Type or print) First Middle Last DOUGLAS CLINTON MARTIN		4. DATE OF DEATH Month Day Year NOV. 18. 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY ON FARM	9. AGE (In years) 1st birthday Months Days 78 11 10
11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME MONROE MARTIN		13b. MOTHER'S MAIDEN NAME SARAH MURRELL	
14. NAME OF HUSBAND OR WIFE SINGLE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Carla Childers Jamestown, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic 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) 4200			INTERVAL BETWEEN ONSET AND DEATH ?
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT <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	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the _____ stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. L. Decker		22b. ADDRESS Carroll Bonnell Mo	
22c. DATE SIGNED 11/20/58		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 11-21-1958		23c. NAME OF CEMETERY OR CREMATORY BETHEL	
23d. LOCATION (City, town, or county) NEAR JAMESTOWN MO		24. FUNERAL DIRECTOR ADDRESS ALBERT HORNBECK PRAXIE HOME MO	
25. DATE RECD. BY LOCAL REG. 11/21/58		26. REGISTRAR'S SIGNATURE Virginia T. Skjerve	

(Licensed Embalmer's Statement on Reverse Side)

Occur, cause, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *E. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prarie Home*

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.