MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 38 26722

Registered No. ~~37693~~

1 PLACE OF DEATH

County: Shelby

Township: Salt River or Village: or City: Shelbina (NO. , St.; Ward)

Registration District No. 830

Primary Registration District No. 6091

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward M. Marland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb 22, 1853 (Month) (Day) (Year)

7 AGE: 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stock Buyer
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (City or town, State or foreign country): Lakeman, Mo.

PARENTS

10 NAME OF FATHER: Jno. H. Marland

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky.

12 MAIDEN NAME OF MOTHER: Elizabeth Greenwell

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Kate Marland
(Address): Shelbina Mo

15
Filed Aug 8, 1919. Mittie Clay, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 7 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 29, 1919, to Aug 7, 1919, that I last saw h. alive on Aug 7, 1919, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Cancer of Bladder
5 yr
Ho
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
? (Duration) yrs. mos. ds.

(Signed) J. A. Furnish M. D.
Aug 8, 1919 (Address) Shelbina

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Shelbina Mo
DATE OF BURIAL: Aug 9, 1919

20 UNDERTAKER: Glenn Hamilton
ADDRESS: Florence Mo

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil*

Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hem-

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Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death o hospital or give its NA of street and

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 19
(Month) (Day)

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to .....

that I last saw h.....alive on .....

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos...

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos..

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury; and (2) whether Accidental, Suicidal or I

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, T or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mo

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURI
20 UNDERTAKER	ADDRESS