

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

Do not use this space.

36555

**1. PLACE OF DEATH**

County Greene  
Township Springfield  
City Springfield (No. 258)

Registration District No. 318  
Primary Registration District No. McAllister

File No. ....  
Registered No. 768 St. .... Ward

**2. FULL NAME**

(a) Residence. No. 258 McAllister St. .... Ward. ....  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Ethel Marshall

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
37 | 4 | 10 | — hrs. — min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Janitor  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Ark.  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Henderson Marsh

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ark  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

14. INFORMANT Ethel Marshall  
(Address) 258 McAllister

15. FILED 12/16 1927 O. C. Forest REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1927, to Dec 14 1927, that I last saw him alive on Dec 14 1927, and that death occurred, on the date stated above, at 12 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) Pulmonary Edema  
(duration) 2 yrs. — mos. — da.

18. WHERE WAS DISEASE CONTRACTED ?  
IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) N. T. Hunter, M. D.  
, 19 (Address) 325 1/2 Booneville Ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lincoln Memorial DATE OF BURIAL Dec 18 1927

20. UNDERTAKER N. Campbell ADDRESS 869 Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

