6 23 1928

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

Do not use this space.

23409

1. PLACE OF DEATH
County: Dekalb — Registration District No. 259 — File No.
Township: Camden — Primary Registration District No. 4158 — Registered No.
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Susan Alice Marshall
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem.	White	Marrked

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: F. M. Marshall

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar. 22nd, 1849

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	4	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: John Baber
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Tenn.
12. MAIDEN NAME OF MOTHER: Julia Acre
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Tennn.

14. INFORMANT: Wm. Marshall
(Address): Maysville Mo.

15. FILED: July 17, 1928 — J. L. Wheelyes, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 17 1928

17. I HEREBY CERTIFY, That I attended deceased from June 9th, 1928, to July 17, 1928, that I last saw h. alive on July 17, 1928 and that death occurred, on the date stated above, at 12 25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver, Gall Bladder & Duodenum.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Dr. R. R. Reynolds, M.D.
, 19 (Address) Maryville, Mo.

*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	DATE OF BURIAL
Oak Lawn Cemetery Maysville	7/19 19

20. UNDERTAKER	ADDRESS
U. G. Pilcher	Maysville

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.