

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

Do not use this space.

6163

1. PLACE OF DEATH

49 County Gasper Registration District No. 11
 7 Township Galena Primary Registration District No. Road
 5 City Johnson (No. _____ St. _____ Ward)

2. FULL NAME

Blanche Marshall

(a) Residence, No. 1902 Pearl St. Ward. _____

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-5-33, 19

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF R-E Marshall

22. I HEREBY CERTIFY, That I attended deceased from Jan 24 33, to July 4 33

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 18, 1894

I last saw her alive on _____, 19____. Death is said to have occurred on the date stated above, at 2:45 AM.

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
38 8 18

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 1 Super
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

Pulmonary
Laryngeal Tuberculosis
 Other contributory causes of importance:
23 23

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

13. NAME Rever U. Skinner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

15. MAIDEN NAME May Winkler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mrs Grace Miller, Johnson Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview Burial Co. 2-7-33

19. UNDERTAKER (ADDRESS) Johnson Mo.

20. FILED 2-7-33 Johnson Mo.
Atkinson Clark
 Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) W S Loveland M. D.
 (Address) Johnson Mo

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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