

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.

MAY 23 1935 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

8457

1. PLACE OF DEATH  
 24 County Clay Registration District No. 197  
 Township Walden Primary Registration District No. 5276  
 City North Kansas City (No. ....) St. .... Ward .....

2. FULL NAME Clay Marshall  
 (a) Residence, No. 2111 Fayette St., ..... Ward.....  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 5 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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED  
 HUSBAND OF Georgia Marsh  
 (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 17 - 1868

7. AGE YEARS 66 MONTHS 11 DAYS 6 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. night watchman  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. W. Luttaker's Battery Supply Co.  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation 5

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

FATHER  
 13. NAME Joseph Marsh  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.

MOTHER  
 15. MAIDEN NAME Margaret Hampton  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.

17. INFORMANT Joe Jim Marsh  
 (ADDRESS) 2111 Fayette

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Truett, Mo. DATE Mar 26 1935

19. UNDERTAKER Morton Funeral Home  
 (ADDRESS) No. 12 Kansas City, Mo.

20. FILED Apr. 9 1935 Viola C. Mayer  
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 23 1935

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....  
 I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 11:30 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Tuberculosis  
 Date of onset .....

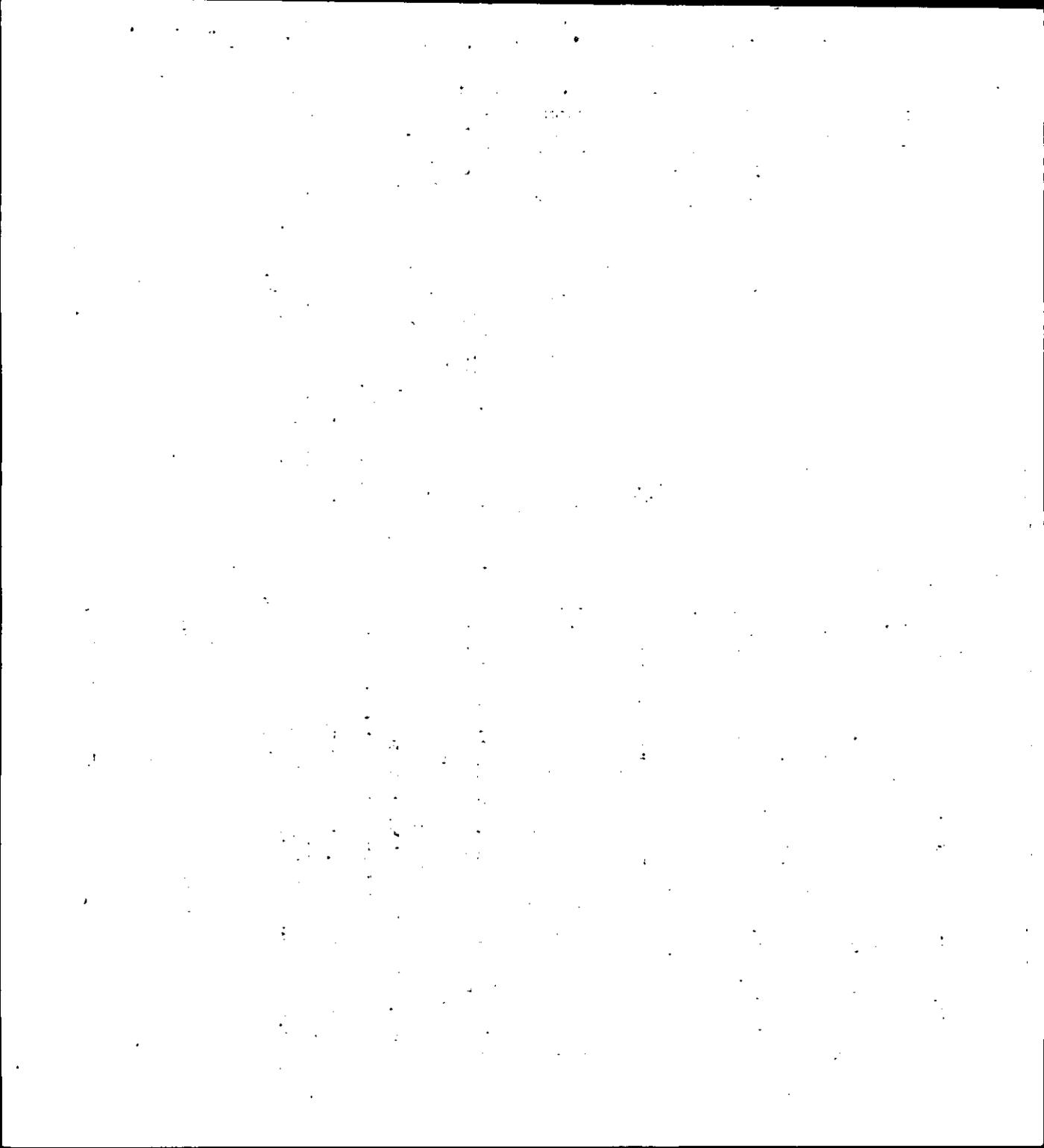
Other contributory causes of importance:  
SIOM

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) Catherine Young, Coroner  
 (Address) Liberty Clay Co Mo



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

Do not use this space.

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Clay  
Township \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 197  
Primary Registration District No. 5276

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
66 11 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19.

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED Apr 9 1935 Viola C. Moyer Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 29 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw \_\_\_\_\_ on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

**DEATH CERTIFICATE**  
pedestrian accident  
leg as crossing highway  
pedestrian at  
time of accident  
Other contributory causes of importance: \_\_\_\_\_  
Date of onset \_\_\_\_\_

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. yes Date of injury 3-23, 1935  
Where did injury occur? 14th Burlington, North  
R.C. Mo. (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
State Highway Inspection 21  
Manner of injury Fractured skull - crushed  
Nature of injury Chest, both legs broken  
lips broken, deep gash on face.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

Exact statement of OCCUPATION is very important.

JUN 20 1955

S-8457