

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.

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

Do not use this space.

JUL 30 1935

22081

1. PLACE OF DEATH

County DADE
Township ELKHART
City _____ (No. _____ St. _____ Ward)

Registration District No. 49
Primary Registration District No. 5077

File No. _____
Registered No. _____

2. FULL NAME ROBERT MARSHALL

(a) Residence. No. RD#2 - ADRAIN, MO. Ward. _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF SARAH MARSHALL (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) AUG. 9, 1845

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
<u>89</u>	<u>11</u>	<u>5</u>		

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER JAMES MARSHALL

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

12. MAIDEN NAME OF MOTHER SARAH MACE

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

14. INFORMANT J. P. MARSHALL
(Address) RD#2 - ADRAIN MO.

15. FILED 7-15-35 Grace L. Linn REGISTRAR
eab.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JULY 14, 1935

I HEREBY CERTIFY, That I attended deceased from Jan 1929 to July 14, 35, to July 13, 35, and that death occurred, on the date stated above, July 14, 1935 at 2 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis
arteriosclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) D. D. LaPlante, M. D.
7/15/35 (Address) Butter, 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 OAK HILL Cem. BUTTER, MO. DATE OF BURIAL JULY 15 1935

20. UNDERTAKER BOOTH ADDRESS RICH HILL MO.

