

Turkey

SEP 18 1935

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

Do not use this space.

25772

1. PLACE OF DEATH

County *Calloway* Registration District No. *1111*
Township *Cleveland* Primary Registration District No. *5760*
City (No. _____) St. _____ Ward _____

2. FULL NAME

Alexander Marshall

(a) Residence, No. _____ 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. 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) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF *Emma Marshall*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr 7-1881*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 4 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Ironer*

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) *Boone Co Mo.*

13. NAME *W. L. Marshall.*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Audrain Co Mo.*

15. MAIDEN NAME *Lecora Sims*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Boone Co Mo.*

17. INFORMANT (ADDRESS) *Mrs Alex Marshall
Hallsville Mo.*

18. BURIAL, CREMATION, OR REMOVAL *Decker near Cen. Aug 22 1935*

19. UNDERTAKER (ADDRESS) *Central Mo.*

20. FILED *722* 1935 *B. H. Stephens*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 20th 1935*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 15 1935* to *Aug 20th 1935*

I last saw him alive on *Aug 19th 1935*. 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:

Cerebral Hemorrhage

Other contributory causes of importance _____

Name of operation _____ Date of _____
What test confirmed diagnosis? *Phys Exam* Was there an autopsy? *No*

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? *No*

If so, specify _____ (Signed) *[Signature]* M. D.
(Address) *Centralia*

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.

WHITE PAINLESS, WITH UNFADING INK—THIS IS A PERMANENT RECORD

