

REC'D FEB 11 1939

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

3596

Do not use this space.

## 1. PLACE OF DEATH

(a) County Ralls. Registration District No. 727  
(b) Township \_\_\_\_\_ Primary Registration District No. 4433 Registered No. \_\_\_\_\_  
(c) City Perry. (d) Street No. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Wm Lyman Marker.  
(a) Residence, No. Perry, Missouri. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## 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 (OR) WIFE OF Laura Craig Marker.  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 25, 1863.  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 10 18  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer.  
9. Industry or business in which work was done, as saw mill, bank, etc. Unemployed.  
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) Illinois.

13. NAME John Marker.

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

15. MAIDEN NAME Mary Brunk.

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

17. INFORMANT (ADDRESS) Mrs Laura Marker.  
Perry Missouri

18. BURIAL PLACE Lick Creek. DATE 1 / 14 / 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Clyde C. Wilsey  
Perry Missouri

20. FILED 1 / 14 / 39 Clyde C. Wilsey  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 / 13 / 39.

22. I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1938, to 1-13, 1939  
I last saw him alive on Jan. 10, 1939 Death is said to have occurred on the date stated above, at 4:30 a.m.  
The principal cause of death and related causes of importance were as follows:

mental delirium + Coma Date of onset 1-10-39

Other contributory causes of importance: Fracture of neck of femur ✓ Dec. 6-38

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? no  
If so, specify \_\_\_\_\_ (Signed) Dr. E. T. Swan M. D.  
(Address) Perry, Mo.

19412  
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

*Clyde C. Wilbey* .....

or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

*Clyde C. Wilbey* .....

Licensed Embalmer No. ....

*3820*

P. O. Address .....

*Perry, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

3596  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Ralls Registration District No. 727  
 (b) Township ..... Primary Registration District No. 4433 Registered No. ....  
 (c) City Perry (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm Lyman Marker  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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.  
75 10 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 .....

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 1959

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... 19...  
 I last saw h..... alive 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:  
mental delirium & coma Date of onset 1958  
 Other contributory causes of importance:  
fracture of neck of femur  
 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? accident Date of injury....., 19.....  
 Where did injury occur? home - Perry (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
home fall  
 Manner of injury.....  
 Nature of injury fracture of neck of femur  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify..... (Signed) E. T. Person M. D.   
 (Address) Perry Mo.

SUPPLEMENTAL

RIGHTS: SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED BY LAW. MOORE

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