

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

3985
Do not use this space.

REC'D FEB 21 1939

1. PLACE OF DEATH
 (a) County Saline Registration District No. 796
 (b) Township Marshall Primary Registration District No. 3038
 (c) City Marshall, Mo. (d) Street No. So. Lincoln 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 Minnie Lee Yorrell
 (a) Residence, No. Marshall A. F. D. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Earl Yorrell
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 18, 1903
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 1 10
 OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Housewife
 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) Marshall, Mo.

FATHER 13. NAME George F. Buile

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall, Mo.

MOTHER 15. MAIDEN NAME Ella S. Smith

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Mo.

17. INFORMANT (ADDRESS) Earl Yorrell
Marshall, Mo. A. F. D.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Ridge P. Cem. DATE Jan 30 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. L. Surgeny
Marshall, Mo.

20. FILED 1-30-39 Mary Kent
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-28 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-10 1939 to 1-28 1939

I last saw h. aw alive on Jan 28 1939. Death is said to have occurred on the date stated above, at 8:10 p. m.

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

Pulmonary Embolism

Other contributory causes of importance:

Cholelithiasis

Name of operation Cholelithotomy Date of 1-10-39
 What test confirmed diagnosis Cholelithotomy 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) Rev. J. L. Surgeny, M. D.
Marshall, Mo. (Address)

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.

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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, ✓

or by

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

Signed

J. Leslie Sweeney
Licensed Embalmer No. 3235

P. O. Address *Marshall, W. Va.*

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.

RECEIVED
District Health Officer No. 8
File Number
11/9/39
Filed

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

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1. PLACE OF DEATH
 (a) County Saline Registration District No. 796
 (b) Township _____ Primary Registration District No. 3038 Registered No. 20
 (c) City Marshall (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 Missie Lee Jarrell
 (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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.
35 1 10

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) _____

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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-28-39

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 _____ m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary Embolism
Appendicitis #
cholecystectomy + appendectomy
Gall stones #
 Date of onset 1/21

Other contributory causes of importance:
cholecystectomy + appendectomy
Gall stones #
 Name of operation _____ Date of _____ 1-10-39
 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) Robt H. Kennedy, M. D.
 (Address) Marshall Mo.

SUPPLEMENTAL

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETELY PREPARED BY LAW.
 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.

Local Registrar.

