

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

**7319**  
 Do not use this space.

**REC'D MAR 17 1939**

**1. PLACE OF DEATH**

(a) County New Madrid Registration District No. 1133  
 (b) Township West Primary Registration District No. 5999A Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
 (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**

621 Ada Bell Marchbanks

(a) Residence, No. Route 3 Sikeston 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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. W. Marchbanks

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 14, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 1 6

OCCUPATION 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. Housewife  
 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) Decatur County Tennessee

FATHER 13. NAME Jessie Livingston

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

MOTHER 15. MAIDEN NAME Hess Pratt

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

17. INFORMANT (ADDRESS) J. W. Marchbanks Sikeston, Missouri

18. BURIAL PLACE Dogwood Cemetary DATE February 22, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. J. Welsh Sikeston, Missouri

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from December 1, 1937 to February 20, 1939. I last saw her alive on Feb. 20, 1939. Death is said to have occurred on the date stated above, at 8:40 P.M.

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

Broncho-pneumonia  
Coronary Heart Disease

Date of onset Feb. 1-31  
Aug. 1, 1938

Other contributory causes of importance:

General Arteriosclerosis Aug. 1, 1938  
Contusion to left shoulder Feb. 5, 1939

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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) Wm. Lynn Henderson M. D.  
 (Address) Sikeston, Mo.

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.

9412

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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, .....

*H. J. WELSH*

....., or by .....

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

Signed.....

*H. J. Welsh*

Licensed Embalmer No. ....

*774*

P. O. Address .....

*Sixton, 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.

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

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1. PLACE OF DEATH  
 (a) County New Madrid Registration District No. 1133  
 (b) Township West Primary Registration District No. 3999A Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (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 Ada Bell Marchbanks  
 (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 F 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.  
69 1 6

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\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-20-1939

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:  
Broncho Pneumonia  
Coronary Heart Disease  
Arteriosclerosis  
Contusion to left shoulder  
 Date of onset 8/19/34  
2/3/39

Other contributory causes of importance:  
 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 2-5-1939  
 Where did injury occur? at home, Lebanon, Mo.  
 (Specify city of town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
In home  
 Manner of injury Tripped and fell on left shoulder  
 Nature of injury Swelling and bruise

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Weldon J. Anderson M. D.  
 (Address) Lebanon, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY MOORE  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

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1. PLACE OF BIRTH

(a) County New Madrid Registration District No. 1133  
(b) Township West Primary Registration District No. 3999A Registered No. 9  
(c) City..... (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 Ada Bell Marchbanks

(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 Female 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 J. W. Marchbanks

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-14-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 1 6

8. Trade, profession, or particular kind of work done, as sawyer, 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) Decatur Co. Tenn

13. NAME Jessie Livingston

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

15. MAIDEN NAME Hess Pratt

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

17. INFORMANT (ADDRESS) J. W. Marchbanks  
Director

18. BURIAL, CREMATION, OR REMOVAL PLACE Logwood Ave DATE 2-22-39

19. FUNERAL DIRECTOR (ADDRESS) H. J. Welsh  
Director

20. FILED April 18 1939 Gas D. Koehler  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 20, 1939

22. I HEREBY CERTIFY That I attended deceased from Dec 1937 to Feb 20, 1939

I last saw him alive on Feb 20, 1939. Death is said to have occurred on the date stated above, at 8:40 a.m.

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

Broncho Pneumonia  
Coronary Heart Disease

Date of onset

8-15-34

Other contributory causes of importance:  
General Arterio Sclerosis  
Contusion to left shoulder

2/5/39

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) Merling Anderson, M. D.  
(Address) Director

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.