WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

OCT 12 1939

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

31941
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan
(b) Township or
(c) City St Joseph
Registration District No. 85
Primary Registration District No. 1001
Registered No. 991
(d) Street No. State Hospital No. 2 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 624 Edith Marshall
(a) Residence, No. State Hospital No. 2 St. St. Joseph
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1898
7. AGE YEARS 41 MONTHS ? DAYS ? If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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) Missouri

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) Records of State Hospital No. 2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Kirksville, Mo. DATE 9-26-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Summers and Finnenpaugh Kirksville, Mo.

20. FILED Sept. 28, 1939 H J Mattlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-23, 1939, to 9-25, 1939
I last saw her alive on 9-24, 1939. Death is said to have occurred on the date stated above, at 9:50 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary tuberculosis	?
23	
Other contributory causes of importance: Congenital idiocy	1898

Name of operation ..... Date of .....
What test confirmed diagnosis? X-ray 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) T. T. O'Dell, M. D.
(Address) St Joseph

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.