

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33616
Registrar's No. 152

Registration District No. 796

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
76 West Jackson St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Female race white

6. (a) Single, widowed, married,
divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive years

7. Birth date of deceased Sept 11 1939
(Month) (Day) (Year)

8. AGE: Years Months Days
4

If less than one day
hr. min.

9. Birthplace Marshall, Mo.
(City, town, or county)

(State or foreign country)

10. Usual occupation Infant

11. Industry or business

12. Name Edgar Caton

13. Birthplace Saline, Mo.

14. Maiden name Marslet

15. Birthplace Longwood, Mo.

16. (a) Informant's own signature Edgar Caton

(b) Address Marshall, Mo.

17. (a) Buried
(Burial, cremation, or removal)

(c) Place: burial or cremation Arrow Rock, Mo.

18. (a) Signature of funeral director J. Leslie Bussing

(b) Address Marshall, Mo.

19. (a) 9-15-39
(Date received local registrar)

(b) Dep. Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Marshall, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 76 Jackson St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 15
year 1939 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-11
1939 to 9-15, 1939
that I last saw him alive on 9-15, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death convulsions
began soon after birth

Due to Cerebral birth injury

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) X
(b) Date of occurrence X
(c) Where did injury occur? X
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury X

23. Signature Alf Putnam (M. D. or other)
Address Marshall, Mo. Date signed 9-16-39

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/10/39

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. 3235

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

33616

Do not use this space.

1. PLACE OF DEATH

(a) County Saline

Registration District No. 796

(b) Township Marshall

Primary Registration District No. 3238

Registered No. 152

(c) City Marshall

(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

(a) Residence, No. _____

St. ☐

(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

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

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

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

Sept 11 1939

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.

4

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.

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

1-11-

19

40

Mary Kent

Sp. Reg.

Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

39

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

Sept 15 1938

22. I HEREBY CERTIFY, That I attended deceased from

_____ 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:

Date of onset

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? _____ 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) A. C. Peterson, M. D.

(Address) Marshall

