

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

6124
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township 3 Primary Registration District No. 3008 Registered No. 37
 (c) City Fulton (d) Street No. State Hospital # 1 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 Helen C. Marschauser
 (a) Residence, No. Fayette Missouri R.R. #10 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single
 (write the word)
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF July 25, 1881
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25, 1881
7. AGE YEARS 58 MONTHS 6 DAYS 13
 If LESS than 1 day, hrs. or min.
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. Housework.
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** John Marschauser

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

MOTHER **15. MAIDEN NAME** Rebecca Falkner

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

17. INFORMANT (ADDRESS) Hay Records State Hwy #1 Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Log Chapel **DATE** Feb. 10 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. N. Crews

20. FILED Feb. 8 1940 R. N. Crews
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 7 1940
22. I HEREBY CERTIFY, That I attended deceased from December 27 1939 to February 7 1940
 I last saw her alive on February 7 1940 Death is said to have occurred on the date stated above, at 9:55 P.M.
 The principal cause of death and related causes of importance were as follows:
Coronary Occlusion
 Date of onset 9/4/40
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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?
 If so, specify.....
 (Signed) Katherine Shirley, M. D.
 (Address) State Hospital #1 Fulton, 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.

FILED MAR 11 1940

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 *W. J. K.*

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

Signed *Opel Roberson*

Licensed Embalmer No. *4101*

P. O. Address *Wigley, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6124

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Helen Elmarschauer

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 58 Months 6 Days 13 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

20. DATE OF DEATH: Month Feb day 7 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (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) _____ (c) Means of injury _____

23. Signature Katherine Shirley (M. D. or other) _____

Address State Hosp #1 signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

