

FILED MAR 14 1940

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. 37

1. PLACE OF DEATH

(a) County Saline

(b) City or town Marshall  
(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 60 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Marshall  
(If outside city or town limits, write "RURAL")

(d) Street No. N. English  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME PET A. PAXTON

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18  
year 40 hour 9:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1940, to Feb 18, 1940  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color Negro 6. (a) Single, widowed, married, divorced Widowed

7. Birth date of deceased Dec. 25 1866  
(Month) (Day) (Year)

8. (b) Name of husband or wife George Paxton 8. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death Cerebral Hemorrhage Duration 6 days

Due to Ch 93C

8. AGE: Years 73 75 Months 1 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions Chromocystoma  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace Miami Saline Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER { 12. Name George Holivar 9

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

14. Maiden name Unknown 9

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

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? \_\_\_\_\_

16. (a) Informant's own signature Mrs. Ida Harris

(b) Address 1325 E 16 St Kansas City Mo

17. (a) Marshall Mo (b) Date thereof Feb 20 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director J. D. Ferguson

(b) Address Marshall Mo 712

19. (a) 2-20-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 1

Address Marshall Date signed 2/20/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED  
District Health Officer No. 8,  
District File Number  
3-12-40  
Date Filed

**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 F. D. Ferguson  
Licensed Embalmer No. 2172  
P. O. Address Marshall

**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. 8255  
Registrar's No. 37

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 796 Primary Registration District No. 3038

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Pet a. Paston

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

4. Sex..... 5. Color or race..... 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..... Dec 25 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>75</u>	<u>11</u>	<u>23</u>

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) 4-15-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18  
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) (e) Means of injury.....

23. Signature J. P. Simmons (M. D. or other)

Address Marshall Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

