

FILED MAR 1 - 1940

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

8280
Do not use this space.

1. PLACE OF DEATH

(a) County Scotland Registration District No. 809
(b) Township Harrison Primary Registration District No. 6054
(c) City or Harrison (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

(a) Residence, No. 620 Kathryn Marsh St. (If nonresident, give city or town and State)
Worm Rural (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE whit 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edward Marsh
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/5/1894
7. AGE YEARS 45 MONTHS 11 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.
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) Quilley Mo

FATHER 13. NAME Walter Fowler

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland Co, Mo

MOTHER 15. MAIDEN NAME Martha F. Cunningham

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland Co Mo

17. INFORMANT (ADDRESS) Cornelita Lestreich
Harrison Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Quilley DATE 3/10/1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Daily Undertaking Co
Quilley Mo

20. FILED Feb-10 1940 Mrs R E Shacklett
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 9th 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 10 1940, to Feb 8th 1940.

I last saw h. or alive on Feb 8 1940 Death is said to have occurred on the date stated above, at 2:15 P.m.
The principal cause of death and related causes of importance were as follows:

Mitral Regurgitation

Date of onset 1938

Other contributory causes of importance:

Arterio Sclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinical 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) F. M. Johnson M. D.
Harrison Mo (Address)

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.

FORM 1 X18605

MAY 5 1948

LS. 64 2

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **8280**

Registration District No. **809**

Primary Registration District No. **6054**

Registrar's No. **6054**

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

1. PLACE OF DEATH
(a) County **Scotland**
(b) City or town **Harrison rural**
(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 **Katheryn Marsh**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **m**
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 **45** Months **11** Days **3** If less than one day _____ min.

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **April 15-40** (b) **M. W. R. Shacklett**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Scotland**
(c) City or town **Gorich Rural**
(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 **8**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Duration _____
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: **F. M. Johnson** (M. D. or other) _____

Address: **Gorich** _____ signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

