

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17381

State File No.

Registration District No. 399

Primary Registration District No.

1002

Registrar's No.

1908

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3725 State Line
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution -- (Specify whether
In this community 50 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3725 State Line
(If rural, give location)
(e) If foreign born, how long in U. S. A. -- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1940 hour 5 minute 50 P.A.M.

21. I hereby certify that I attended the deceased from
April 18 1940 to May 5 1940
that I last saw him alive on May 2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Nemia Duration 1 wk.

Due to Chronic nephritis 2 mo.
acute excretion

Due to 94% per leucemia Cordis 5 yrs.
renal disease

Other conditions: 131
(Includes pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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 transport _____

23. Signature A. Council M.D. (M. D. or other) _____
Address 814 Medical Arts Bldg. Date signed 5/6-40

3. (a) PRINT FULL NAME Mr. Thomas Franklin Marshall

3. (b) If veteran, name war None 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Lenora Marshall 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased September 7 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 7 28 hr. min.

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

10. Usual occupation Car Repair Man --Retired

11. Industry or business Rock Island Lines

MOTHER FATHER { 12. Name Thomas Marshall

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

14. Maiden name Mary McVey

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

16. (a) Informant Mrs. Lenora Marshall

(b) Address 3725 State Line

17. (a) Burial (b) Date thereof May 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill-K.C. Kans.

18. (a) Signature of funeral director D. H. Newcomer's son

(b) Address 1401 Brush Creek Bldg.

19. (a) May 7, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

1:30-5

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 *Emile M. Calhoun*

Licensed Embalmer No. *3506*

P. O. Address *TC Mo.*

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.