

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 state 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

1925

Registration District No. 689 Primary Registration District No. 3033 State File No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Louisiana
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 9
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) _____

3. (a) PRINT FULL NAME Dorothy Louise Marsh
3. (b) If veteran, name war L 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race Black 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 Jan 28 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name Stanley D Marsh
13. Birthplace Windsor, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elsabeth Wilson
15. Birthplace Louisiana Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Marsh
(b) Address Louisiana Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/40
(Month) (Day) (Year)
(c) Place: burial or cremation Mt Zion Pike Co Mo

18. (a) Signature of funeral director P. H. Bailey
(b) Address Louisiana, Mo
19. (a) 5/26/40 (Date received local registrar) (b) J. Chary (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Louisiana
(If outside city or town limits, write "RURAL")
(d) Street No. So Main
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 26
year 1940 hour _____ minute 9:24 A.M.
21. I hereby certify that I attended the deceased from 5/28, 1940, to 5/24, 1940.
that I last saw her alive on May 24, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchial Pneumonia
Due to nephritis
Due to _____
Other conditions (Include 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? 620
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Emil Payne (M-D-number) D.O.
Address Louisiana Mo Date signed 5/26/40

1302

4161
9761

RECEIVED

District Health Office No. 10

District File Number 62-42-1112

Date Filed JUN 6 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.....

George O. Wagner

Registered Apprentice No.....

working under my personal supervision.

Signed *George O. Wagner*

Licensed Embalmer No. *3173*

P. O. Address *Louisiana, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19257

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 689

Primary Registration District No. 2033

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Perse

(b) City or town Louisiana Mo
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dorothy Louise Marsh

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race black

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

(Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months 3 Days 28

If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director None

(b) Address _____

19. (a) 717-40 (b) J. Neely
(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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 26
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia
relapsing (toxic)
Due to Extension of an acute bronchitis
Due to Pneumonia

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 Emil Mayer (M. D. or other) _____

Address Louisiana Mo Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-19257