

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26408

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

796

3038

118

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:  
Fitzgibbon Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community 18 years  
 years, months or days

8. (a) PRINT FULL NAME Truby B. Marshall

8. (b) If veteran, name war ✓ 8. (c) Social Security No. 6211

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Irish H. Marshall 6. (c) Age of husband or wife if alive 54 years  
 7. Birth date of deceased July 10 1886  
 (Month) (Day) (Year)

8. AGE: Years 54 Months 0 Days 15 If less than one day hr. \_\_\_\_\_ min. 0

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

10. Usual occupation Stump Ripper

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name John Spring  
 13. Birthplace Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Ada Taylor  
 15. Birthplace Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. A. H. Sullivan

(b) Address 36 N. 70. K.C. Mo.

17. (a) Burial (b) Date thereof July 27-1940  
 (Burial, cremation, or removal) (Monthly) (Day) (Year)

(c) Place: burial or cremation Bethlehem Cem.

18. (a) Signature of funeral director Charles Smith

(b) Address Marshall, Mo.

19. (a) 7-26-40 (b) Def.  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
 (c) City or town Marshall, Tenn.  
 (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 July day 25  
 year 1940 hour 11- minute 30 P. M.

21. I hereby certify that I attended the deceased from July 19, 1940, to July 25, 1940;  
 that I last saw her alive on July 25, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death quite nephritic & interstitial  
 Duration \_\_\_\_\_

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

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

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

PHYSICIAN

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 \_\_\_\_\_

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? Yes

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

23. Signature John R. Lawrence (M. D. or other) \_\_\_\_\_

Address Marshall, Mo. Date signed July 26-40

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. MAKE A PERMANENT RECORD

121

RECEIVED  
District Health Officer No. 8,  
District File Number  
8-12-40  
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, ~~of~~.....

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

Signed James H. Lewis  
Licensed Embalmer No. 1171  
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. **26408**  
Registrar's No. **118**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **796**

Primary Registration District No. **2038**

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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

**Ruby B. Marshall**

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 **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 **54**

Months **0**

Days **15**

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) \_\_\_\_\_

(Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_

(Date received local registrar)

(b) \_\_\_\_\_

(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.

MENTAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **25** -  
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 **Acute Nephritis** Duration \_\_\_\_\_

**Interstitial**

Due to \_\_\_\_\_

Due to **unknown cause**

**N.M.D.**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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

PHYSICIAN

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 injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

