

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11384**

Registration District No. **556**

Primary Registration District No. **4728**

Registrar's No. **48**

1. PLACE OF DEATH:

(a) County **Mercer**
(b) City or town **Princeton**
(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)

3. (a) PRINT FULL NAME

Marion J. Showalter

3. (b) If veteran, name war _____

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. Kate Showalter**

6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **March 9, 1863**

(Month) (Day) (Year)

8. AGE: Years **77** Months **6** Days **24** If less than one day _____ min.

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

10. Usual occupation **Merchant-Retired**

11. Industry or business _____

12. Name **Jacob Showalter**

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

14. Maiden name **Catherine Johnson**
(City, town or county) (State or foreign country)

15. Birthplace **Ohio**
(City, town or county) (State or foreign country)

16. (a) Informant's own signature **Kate Showalter**

(b) Address **Princeton Mo**

17. (a) **Rural** (b) Date thereof **Oct 5-10**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Princeton Cemetery**

18. (a) Signature of funeral director **Walter F. ...**

(b) Address **Home - Princeton Mo**

19. (a) **10/4-40** (b) **J. M. Perry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mercer**
(c) City or town **Princeton Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **City**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **3d**
year **1940** hour **12** minutes **50 PM**

21. I hereby certify that I attended the deceased from **9:05**
3 1940 to **Oct 3** 1940
that I last saw him alive on **Oct 3** 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy** Duration **3 days**

Due to _____

Due to **Corticoparasymp**

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

Major findings: Of operations _____

Of autopsy **no**

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? **444**

While at work _____ (Specify type of place) (e) Manner of injury _____

23. Signature **A. S. Bristol** (M. D. or other) _____

Address **Princeton Mo** Date signed **10/4-40**

WRITE CLEARLY—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.

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.