

FILED AUG 25 1941

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 204

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(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 1 (Specify whether years, months or days)

3. (a) PRINT FULL NAME KATIE RUTH MARSHALL

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex F 5. Color or race Alb 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 12 - 40 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
9 13 hr. min.

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

10. Usual occupation Infant

11. Industry or business

12. Name

13. Birthplace

14. Maiden name Milena Marshall

15. Birthplace Boone Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Milena Marshall

(b) Address 9 W. Walnut

17. (a) Burial (b) Date thereof 7. 26. 41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savary Cem

18. (a) Signature of funeral director A. B. Freeman

(b) Address 60 S Park Ave Columbia Mo

19. (a) 7/31/41 (b) Allie Selby (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 9 1/2 West Walnut St (If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 25 day July year 1941 hour 3 minute 15 M.

21. I hereby certify that I attended the deceased from Dec 12, 1940, to July 25, 1941, that I last saw her alive on July 5, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Malnutrition  
Not given's been  
giving problems  
Due to terminal  
pneumonia tubercular  
Due to 10dy

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

Major findings: non  
Of operations 58

Of autopsy none

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 AW Kaufmann (M. D. or other) 0  
Address Columbia Mo Date signed

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

MOTHER FATHER

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

010  
24

AUG 28 1944

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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed: \_\_\_\_\_

A. C. Freeman

Licensed Embalmer No. \_\_\_\_\_

2837

P. O. Address \_\_\_\_\_

608 Park Ave Columbus

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, fact should be so stated above.