

Registration District No. 607

Primary Registration District No. 5997

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Bokerton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Bokerton, Missouri
(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.? 0 years.

3. (a) PRINT FULL NAME John H. Marshal

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

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

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

7. Birth date of deceased May 16 1869
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 6 If less than one day hr. -- min.

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

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Frank Marshal

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

14. Maiden name Jane Talley

15. Birthplace Macon Co. Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie Marshal

(b) Address Bokerton, Mo.

17. (a) Burial (b) Date thereof Aug. 24, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portageville, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Caruthersville, Mo.

19. (a) _____ (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23
year 1941 hour 6 minute 0 A. 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 no medical attention - from record acute Cor. Failure

Due to _____

Due to _____

Other conditions 200a
(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 5

23. Signature [Signature] Cotone
Address New Madrid Date signed Aug 24 1941
(M. D. or other)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2;

District File Number 1041-6400

Date Filed 10/8/41

OCT 10 1951

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

James A. Osburn

Licensed Embalmer No. 4185

P. O. Address Southsville, N.C.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32085
Registrar's No. _____

Registration District No. 604

Primary Registration District No. 5798

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Robertson
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John H. Marshall

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

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

May 16 1868
(Month) (Day) (Year)

8. AGE:

Years 72 Months 4 Days _____
Of less than one day _____ min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry of 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

(b) Address

19. (a) 11-10-41
(Date received local registrar)

(b) Wm O'Bannon
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 23
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ live on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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 _____

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

SUPPLEMENTARY

NEW MARIANA

32085