

FILLED NOV 4 1941

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 990

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

1. PLACE OF DEATH: **BUCHANAN**

(a) County _____

(b) City or town **ST. JOSEPH** *Clear*

(c) Name of hospital or institution **STATE HOSPITAL No. 2**

(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution **2 1/2 Mo. 2** (Specify whether _____)

In this community **One Month** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City Missouri**

(If outside city or town limits, write "RURAL")

(d) Street No. **224 East 32nd St Tenard**

(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **LIDA MARSHALL**

(b) If veteran, name war **No**

(c) Social Security No. **487-05-2926**

20. DATE OF DEATH: Month **October** day **13** year **1941** hour **11:30** minute **P** M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Henry V Marshall** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **July 27 1893** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug 29** 19 **41** to **October 13** 19 **41**; that I last saw her alive on **October 13** 19 **41**; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	46	46	2	16 33 hr. 30 min.

Immediate cause of death **Carcinoma of Left Breast, 2+ yrs with metastasis**

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

Due to _____

Due to **50**

10. Usual occupation **waitress**

Other conditions **Psychosis with Syphilitic Meningoencephalitis**

(Include pregnancy within _____ months of death)

11. Industry or business **Waldman Restaurant K.C. Mo**

Major findings: _____

Of operations **none**

12. Name **J. S. Craig**

Of autopsy **none**

13. Birthplace **Kanawha County Mo** (City, town, or county) (State or foreign country)

14. Maiden name **in any Payne**

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

16. (a) Informant **Mr. Frank Sims**

(b) Address **Windsor Mo.**

17. (a) **Removal** (b) Date thereof **Oct 15, 1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Windsor Mo.**

18. (a) Signature of funeral director **Kerman W. Sledge**

(b) Address **1802 Union St St Joseph Mo**

19. (a) **Oct 14, 1941** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

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) **no**

(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 **D R Edwards** (M. D. or other) **MD**

Address **State Hosp # 2** Date signed **10-14-41**

NOV 3 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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Albert C. Harrington
Licensed Embalmer No. 3258
P. O. Address St. Joseph, 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, fact should be so stated above.