

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34679**
Registrar's No. **31**

Registration District No. **204**

Primary Registration District No. **20-13**

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

1. PLACE OF DEATH: **Clinton**

(a) County **Clinton**

(b) City or town **Cameron**
Cameron

(c) Name of hospital or institution:
S-Chestnut St.
1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **No**
(Specify whether)

In this community **1.0 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clinton** *25*

(c) City or town **Cameron**
(If outside city or town limits, write "RURAL") *1*

(d) Street No. **S-Chestnut**
(If rural, give location) *0*

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Robt. Wm. Marsh**

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

3. (c) Social Security No. **488-14-2439**
000-0718248

20. DATE OF DEATH: Month **Sept.** day **24**, 1941
year **1941** hour **10:45 P** minute _____ M.

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

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

6. (b) Name of husband or wife **Amy A. Marsh.**

6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **April 5, 1892**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov/Dec 10/39** 19**39** to **Sept 24/41** 19**41**
that I last saw him alive on **Sept 24/41** 19**41**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	49	5	19	hr. _____ min.

Immediate cause of death **General debility**

Due to **Gastric Carcinoma**

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

10. Usual occupation **Log clearing**

11. Industry or business **Pressing & Cleaning**

Other conditions (Include pregnancy within 3 months of death) **H/O**

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER { 12. Name **Andrew J. Marsh.**

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

{ 14. Maiden name **Anna Frankeberger**

{ 15. Birthplace **Freeport Ill.**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Amy Marsh**

(b) Address **Cameron**

17. (a) **Burial** (b) Date thereof **9-26-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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? _____

18. (a) Signature of funeral director **Poland Funeral Home**

(b) Address **Cameron**

19. (a) **Sept 26 1941** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury **2**

23. Signature **A. L. Parney** (M. D. or other) **D.O.**

Address **Quader Mo** Date signed **9-25-41**

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 Gerald F. Wade

Licensed Embalmer No. 4172

P. O. Address Cameron 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.