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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 24 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 1077

Primary Registration District No. 4083

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Shannon Co.

(b) City or town Rural, Castle, P.S.  
(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 \_\_\_\_\_  
years, months or days (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon Co

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

(d) Street No. 11.01, N.E. of Summersville  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DAVID OASLOW MARSHALL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1942 hour 8:45 minute 00 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

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

7. (b) Name of husband or wife B. W. L. H. MARSHALL (c) Age of husband or wife if alive 40 years

7. Birth date of deceased: June 29 1866  
(Month) (Day) (Year)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months \_\_\_\_\_ Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Cerebral Hemorrhage

9. Birthplace Hudson, N.H. (City, town, or county) (State or foreign country)

Due to Hypertension

10. Usual occupation Farming

Due to Arteriosclerosis

11. Industry or business \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

12. Name Jno Benj. Marshall

Major findings: Of operations 8301

13. Birthplace Hudson, N.H. (City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name E. F. F. R.

15. Birthplace Hudson, N.H. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. B. W. L. H. Marshall

(b) Address Summersville

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Removal (b) Date thereat July 20-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hudson, N.H.

(b) Date of occurrence \_\_\_\_\_

18. (a) Signature of funeral director John F. Means

(b) Address Summersville, Mo.

(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? \_\_\_\_\_

19. (a) 7-25-42 (b) Frank R. De Mott  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. J. M. Reeds (Physician)

Address Summersville Date signed 7-20-42

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 842672-

Date Filed 8.21-42

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

*Joe A. Amon*

Registered Apprentice No. 301

working under my personal supervision.

Signed

*John J. Amon*

Licensed Embalmer No. 2516

P. O. Address *11th Street*

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.