

No. 2  
9-4-41  
5-17-39  
X2948  
LED MAR 25 1943 149  
Registration District No. ....

Primary Registration District No. 1002

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
708 HARRISON /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 2 mo.  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 46  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. Hocomo mo  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Paul Marshall3. (b) If veteran, name war none 3. (c) Social Security No. Donation4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Aug 1926  
(Month) (Day) (Year)8. AGE: Years 17 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Hocomo mo (City, town, or county) (State or foreign country)10. Usual occupation Laborer11. Industry or business none12. Name Bell Marshall  
13. Birthplace mo (City, town, or county) (State or foreign country)14. Maiden name Miriam Calhoun  
15. Birthplace mo (City, town, or county) (State or foreign country)16. (a) Informant Robertson Funeral Home  
(b) Address West Plains mo17. (a) Removed onto (b) Date thereof March 15-43  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hocomo mo18. (a) Signature of funeral director Parantinos pers  
(b) Address 712 E 5th19. (a) 3-15-43 (b) M. W. Brown  
(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13  
year 1943 hour 6 minute 45 P. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h Deputy Coroner \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Methane Gas intoxication  
Duration \_\_\_\_\_Due to 179-X  
Due to 14Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy See above  
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) Accident 123(b) Date of occurrence March 13 1943(c) Where did injury occur? Kan. City Jackson mo  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Rooming HouseWhile at work? No (Specify type of place) (e) Means of injury Gas23. Signature D. E. Oscher (M. D. or other) M.D.Address 2312 M. E. Coy Date signed 3/15/43

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

MOTHER FATHER

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.....

*Park G. Rowe*

Licensed Embalmer No.....

*2347*

P. O. Address.....

*H. C. 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1284

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Marshall, James

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 3-15-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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

20. DATE OF DEATH: Month March day 15  
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw him..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death carbon monoxide intoxication

Due to a burning gas stove

Due to.....

Other conditions.....  
(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) (Means of injury)

23. Signature A. E. Wecker (M. D. or other) M. P.  
23 M<sup>o</sup> Co. Date signed 3/15/43

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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