

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

ED APR 30 1943 262

5-8557

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Rural Bayou Township  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clark

(c) City or town Rural Bayou Township  
(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 Berlin Murrel Marshall

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9  
year 1943 hour 8 minute 0 P. M.

21. I hereby certify that I attended the deceased from Dec 1 1942 to March 9 1943  
that I last saw him alive on March 2 1943  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, 2 divorced, Widower

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

7. Birth date of deceased: Jan 6 1956  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Apoplexy

Duration 3 wks

8. AGE: 87 Years Months 2 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

10. Usual occupation: Farmer

Major findings: \_\_\_\_\_

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

Of operations: \_\_\_\_\_

12. Name: Charlie Marshall

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

13. Birthplace: \_\_\_\_\_ (City, town or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name: Kathie Perry

15. Birthplace: \_\_\_\_\_ (City, town or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant: T. R. Colvin

(b) Address: Elijah Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: Mar 12-43  
(Month) (Day) (Year)

(c) Place: burial or cremation: Marshall Cemetery

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: Elijah Mo (M. D. or other) \_\_\_\_\_

Address: \_\_\_\_\_ Date signed: 4-1

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

MOTHER FATHER

RECEIVED

District Health Officer No. 01

District File Number 443-502

Date Filed 4-29-43

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**