

FILED JUN 7 1943

6688322

Primary Registration District No. 44726088

State File No.

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall "Rural"
(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 Saline
(c) City or town Marshall "Rural"
(If outside city or town limits, write "RURAL.")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME "Infant" TRUE

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

4. Sex M 5. Color or race W 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 may - 3 - 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 hr. 45 min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Wm True

13. Birthplace Kansas City Kans
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lou Long

15. Birthplace Saline Mo mo
(City, town, or county) (State or foreign country)

16. (a) Informant Jack Long

(b) Address Marshall mo

17. (a) Burial (b) Date thereof 5-4-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cem Marshall Mo

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) May 10-43 (b) Mrs. Johna Gigu
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month may day 3
year 1943 hour 7 minute 00 P.M.

21. I hereby certify that I attended the deceased from May 3 1943 to May 3 1943
that I last saw him alive on May 2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth Duration 6 1/2 hrs

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) 159

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) (e) Means of injury 0

23. Signature Resault Hallinan (M. D. or other) Mo
Address Marshall Mo Date signed 5-2-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-4-43

cert
6-4-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~ ^{not embalmed} by me, or by

Harry Hershberger

Registered Apprentice No.

334

working under my personal supervision.

Signed

Fred Wilkinson

Licensed Embalmer No.

2478

P. O. Address

Clinton Ma

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

State File No.

Registration District No. (322)

Primary Registration District No. (6088)

Registrar's No. 6

1. PLACE OF DEATH:

(a) County. Saline

(b) City or town. Marshall Rural
(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 Infant True

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

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

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

7. Birth date of deceased May 3
(Month) (Day) (Year)

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

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

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) _____ (b) Date thereof. _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. John Giger
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

S-19194