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2-43
7-39
X552

Registration District No. 157

Primary Registration District No. 5575

Registrar's No. 49

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
1117 East 80th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 16 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1117 East 80th Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mr. Joseph M. Marlatt

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th
year 1943 hour 7 minute A. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Cora B. Marlatt

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased October 22 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 1941 to July 10 1943
that I last saw him alive on July 3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure Duration 3 yrs

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

66	8	19	hr. min.
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Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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

10. Usual occupation Grocer

11. Industry or business Retired

MOTHER FATHER { 12. Name William W. Marlatt

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

14. Maiden name May Davis

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant Mrs. Cora B. Marlatt

(b) Address 1117 East 80th Street

17. (a) Cremation (b) Date thereof July 12, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 7/20/43 (b) W. L. Underhill
(Date received local report) (Registrar's signature)

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 George H. Newcloud (M. D. or other) Dr. 20
Address 520 Professional Bldg Date signed 7-10-43

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..... *Emile M. Calhoun*

Licensed Embalmer No..... *3506*

P. O. Address..... *Kew*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

Registration District No. 154

Primary Registration District No. 2-5-75-

1. PLACE OF DEATH:

(a) County Jackson
(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) (Specify whether

3. (a) PRINT FULL NAME Joseph M Malart

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 M

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

7. Birth date of deceased Oct 22 (Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 22 (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 _____ (City, town, or county) (State or foreign country)

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) _____ (Date received local registrar) (b) _____ (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 July year 1943 minute _____ M. 10

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

Immediate cause of death Cardiac Failure Duration _____
chronic myocarditis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93d

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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) _____

(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 George H. Moreland (M. D. or other) MD

Address 5208 Jefferson Blvd Date signed Aug 16, 43

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

SUPPLEMENTAL

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

AUG 13 1943

Registration District No. 154

Primary Registration District No. 0575

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Washington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
1117 East 80th St
(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 _____ (b) County _____
(c) City or town Rural Washington Twp
(If outside city or town limits, write "RURAL")
(d) Street No. 1117 East 80th St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph M Marlett
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 M
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 22 1876
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days _____ Unless than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER {

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Dr. Annie G. Hedges
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____
year 1943 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

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) _____

(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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY