No. 5-42
17-39

31242

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1061

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 37 days (Specify whether
In this community 62 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton 25

(c) City or town Plattsburg 3
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Cora C. Marshall

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Scott Marshall

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June (Month) 30 (Day) 1870 (Year)

8. AGE: Years 73 Months 3 Days 4 If less than one day hr. min.

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

10. Usual occupation house wife

11. Industry or business

FATHER
12. Name James C. Creel
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucy Frances Gooch
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Beryl Rogers
(b) Address Plattsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Green Lawn

18. (a) Signature of funeral director Jas. L. Martin
(b) Address Plattsburg Mo

19. (a) 10/4/43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 - 4 day - 43
year 9 hour 30 minute 9 M.

21. I hereby certify that I attended the deceased from Aug 27 1943, 19, to 10-4-, 1943
that I last saw her alive on 10-4-, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus — Duration 2 yrs.

Due to Gangrene of foot + amputation.

Due to Fracture of hip

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Gangrene

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) Accident

(b) Date of occurrence 025

(c) Where did injury occur? Home (City or town) (County) (State)

(d) 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 Paul Forgran (M. D. ~~or other~~)
Address St Joseph Mo Date signed 10-4-43

1232

(Licensed Embalmer's Statement on Reverse Side)

Harrison

Joe

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 James L. Martin

Licensed Embalmer No. 4303

P. O. Address Plattsburg

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.

. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. oct

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1061

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (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)

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

3. (a) PRINT FULL NAME Cora C. Marshall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 June (Month) 30 (Day) 1870 (Year)

8. AGE: Years 73 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month oct day 4 year 1963 hour minute M.

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

Immediate cause of death Diabetis mellitis

Due to and gangrene of rt foot & amputation

and Fracture of hip

~~Other conditions~~ (left)
(Include pregnancy within 3 months of death)

Major findings:
Of operations 186a

Of autopsy 18

Duration

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) accident

(b) Date of occurrence no facts

(c) Where did injury occur? Plattsburg (City or town) Mo (County) (State)

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

While at work? (e) Means of injury Fall

23. Signature (M. D. or other)

Address Date signed

31242