

Registration District No. **FILED APR 7 3 1944**

Primary Registration District No. **6117**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **SCOTT**  
(b) City or town **DIEHLSTADT (RURAL)**  
(c) Name of hospital or institution: **Juwananville**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4**  
(Specify whether years, months or days) **ALL OF LIFE**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **SCOTT**  
(c) City or town **DIEHLSTADT**  
(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 **LEATHERA MARSH**

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

4. Sex **M** 5. Color or race **COLORED** 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 **NOV 15 1925**  
(Month) (Day) (Year)

8. AGE: Years **18** Months **2** Days **15** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name **JOHN MARSH**  
13. Birthplace **N.K. N.K. 9**  
(City, town, or county) (State or foreign country)  
14. Maiden name **N.K. N.K.**  
15. Birthplace **N.K. N.K. 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **CORA MILLER**  
(b) Address **DIEHLSTADT, MO.**

17. (a) **BURIAL** (b) Date thereof **1-20-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **BAR GROVE CHARLESTON, MO.**

18. (a) Signature of funeral director **Charles W. ...**  
(b) Address **Charleston, Mo.**

19. (a) \_\_\_\_\_ (b) **MOSE J. ...**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN** day **16**  
year **1944** hour **7** minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from **JAN. 15**  
19**44** to **JAN. 15** 19**44**  
that I last saw him **IM** alive on **JAN. 15** 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Lobar pneumonia**

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

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

Major findings: **108**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of injury) \_\_\_\_\_  
23. Signature **C. C. Presnell** (M. D. or other) **M.A.**  
Address **Charleston, Mo.** Date signed **1-24-44**

RECEIVED

District Health Office No. 2,

District File Number 444-357

Date Filed 7-7-44

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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 John F. Munnell Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.