

S. No. 2  
DM-343  
v. 5-17-39  
I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 14 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6406  
Registrar's No. 707

Registration District No. 177 Primary Registration District No. 3035

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

1. PLACE OF DEATH:  
(a) County Lafayette  
(b) City or town Lexington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Deed at home!  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution Nil  
(Specify whether  
In this community Lifetime  
years, months or days)

3. (a) PRINT FULL NAME John W. Marshall  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. Nil

4. Sex Male 5. Color or race W. C. 6. (a) Single, widowed, married, divorced Married  
(b) Name of ~~husband or~~ wife Mrs. T. Marshall (c) Age of ~~husband or~~ wife if alive 63 years  
7. Birth date of deceased Dec. 27 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 8 If less than one day  
— hr. — min.

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

10. Usual occupation Pensioner

11. Industry or business Nil

12. Name Thomas Marshall

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. T. Marshall

(b) Address Lexington, Mo.

17. (a) Burial (b) Date thereof 2-8-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director Walter Soud  
(b) Address Lexington, Mo.

19. (a) Feb-6-45 (b) Mrs. Fred Schwab  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Lafayette  
(c) City or town Lexington 34  
(If outside city or town limits, write "RURAL")  
(d) Street No. Howard Street 3  
(If rural, give location) 2  
(e) Citizen of foreign country? No (Never No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 4 ch  
year 1945 hour 4 minute 30 a. m.  
21. I hereby certify that I attended the deceased from January 1st, 1945 to Feb 7, 1945  
that I last saw h. in alive on Feb 7, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Degeneration with Acute Pulmonary Edema. Duration 7 days  
Due to Arteriosclerosis of Coronary Arteries 2 months app.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 930 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?

23. Signature W. L. Bellman (Specify type of physician) (e) Means of injury \_\_\_\_\_  
Address Lexington Mo Date signed Feb 7 1945

1158

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3/13/40

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 William Hurley

Licensed Embalmer No. 3105

P. O. Address Lexington, 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.