

FILED MAR 14 1945

Registration District No. **324**

Primary Registration District No. **6093**

Registrar's No. **31**

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

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution Mo State School 7.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Saline

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

(d) Street No. 0
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Lionel James Quinn

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 7

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July 3 1926
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>24</u>	<u>7</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name J. L. Quinn

13. Birthplace Osage Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Caldwell

15. Birthplace Miller Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Records, Mo State School

(b) Address Marshall, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 3-2-45
(Month) (Day) (Year)

(c) Place: burial or cremation Jefferson City Mo

18. (a) Signature of funeral director Hershberger, Funeral Home

(b) Address Marshall, Mo.

19. (a) 72445
(Date received local registrar)

(b) Mo T. Owsen
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 year 1945 hour _____ minute 7:30 P. M.

21. I hereby certify that I attended the deceased from Feb 10 - 45 to Feb 27, 1945; that I last saw him alive on Feb 27, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of bowels abnormal. Diarrhea - spillover

Due to _____

Due to _____

Other conditions 1 1/2
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 0

23. Signature L. S. James M. D. (M. D. or other) _____

Address Marshall Mo. Date signed 2-27-45

1215

RECEIVED

Sanitary Health Officer No. 8,

Public File Number

Date Filed

3/12/43

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 *Harry Hershberger*

Licensed Embalmer No. *4357*

P. O. Address *Marshall 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.