S. No. 2
M—5-43
. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28045

State File No.

FILED SEP 13 1945

Registration District No.

Primary Registration District No. ~~5850~~ 4353

Registrar's No. 14

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Gideon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 (Specify whether
In this community Infant
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid 2
(c) City or town Gideon Mo 1
(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) 0
If yes, name country

3. (a) PRINT FULL NAME J. C. Marrow
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 0
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Aug (Month) 11 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 8 hr. 30 min.

9. Birthplace Gideon (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Calvin Bruce Marrow
13. Birthplace Parkin (City, town, or county) Ark (State or foreign country)
MOTHER
14. Maiden name Lillian Elizabeth White
15. Birthplace Fort Smith (City, town, or county) Ark (State or foreign country)
16. (a) Informant Calvin Bruce Marrow
(b) Address Gideon Mo
17. (a) Mt Gillion (Burial, cremation, or removal) (b) Date thereof Aug 12 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Gilead Cem between Clarkton & Malden
18. (a) Signature of funeral director Family
(b) Address Gideon Mo.
19. (a) Aug. 11-45 (Date received local registrar) (b) Zenda Macon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11 1945
year 1945 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from Aug. 11, 1945, to Aug, 1945
that I last saw him alive on Aug. 11 1945, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Fromen ovale failed to Close
Due to undeveloped heart
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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? (e) Means of injury
23. Signature B. E. Ellis (M. D. or other)
Address Gideon Mo Date signed Aug 11/45

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
District Health Office No. 2
District File Number 945-3
Date Filed 4-11-45

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.