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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED JAN 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **268**

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **49**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution: **Mo. Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 hours**
In this community **59 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1314 So. 25th St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Marie Marshall**
3. (b) If veteran, name war **No** **3. (c) Social Security No.** **None**

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widowed**
6. (b) Name of husband or wife **Jerry C. Marshall** **6. (c) Age of husband or wife if alive** **years**
7. Birth date of deceased **October 25 1865**
(Month) (Day) (Year)

8. AGE: Years **31** Months **2** Days **9** If less than one day **hr. min.**

9. Birthplace **Stuttgart** **Germany**
(City, town, or county) (State or foreign country)
10. Usual occupation **At home**
11. Industry or business **At home**

MOTHER FATHER
12. Name **Frederick Schwend**
13. Birthplace **Unknown** **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Charles Maier**
(b) Address **St. Joseph, Mo.**
17. (a) Burial **(b) Date thereof** **1/7/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park.**

18. (a) Signature of funeral director **Heaton R. Cobb & Burman**
(b) Address **St. Joseph, Mo.**
19. (a) 1-14-47 **(b) A. G. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **4** year **1947** hour **2** minute **0** M.
21. I hereby certify that I attended the deceased from **January second** **1947** to **1-4** **1947**
that I last saw her alive on **1-4-47**, 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** **Duration** **14 hrs.**
left entire lung
Due to **Pneumonitis, acute** **2 days.**

Due to
Other conditions **Generalized Arteriosclerosis** **?**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy **107**
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) (c) Means of injury
23. Signature **A. G. Jenkins** (M. D. or other) **M.D.**
Address **706 Francis** **Date signed** **1-4-47**

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

FEB 19 1947

JUL 28 1947

FEB 20 1947

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..... *Raymond H. Marchand*

Licensed Embalmer No. *4413A*

P. O. Address *39 So 10th St Joseph 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.