

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

FILED FEB 5 1947

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 45

1. PLACE OF DEATH:  
 (a) County Greene  
 (b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
649 - W. Franklin  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) county Greene 39  
 (c) City or town Springfield 16  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 649 - W. Franklin 0  
(If rural, give location)  
 (e) Citizen of foreign country? ✓ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HENRY MARSHALL  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 11 day 14  
 year 1947 hour 9 minute 30 A.M.  
 21. I hereby certify that I attended the deceased from ✓  
Dec. 12 1946 to Jan. 14 1947;  
 that I last saw him alive on Jan 14 1947;  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color of race Negro  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Julia Marshall  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Jan 12 1885  
(Month) (Day) (Year)

Immediate cause of death Cerebrovascular lesion Duration \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. AGE: Years 62 Months 2 Days \_\_\_\_\_  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to fracture, left hip  
Nov. 17, 1947  
 Due to \_\_\_\_\_

9. Birthplace Oakland Miss  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

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

MOTHER: FATHER

11. Industry or business \_\_\_\_\_  
 12. Name Cohn Marshall  
 13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
186A  
1819

16. (a) Informant Mrs. Clara Marshall  
 (b) Address 649 - W. Franklin  
 17. (a) Burial (b) Date thereof 1-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Lincoln Memorial  
 18. (a) Signature of funeral director Herbert V. Smith  
 (b) Address 702 W. Jefferson  
 19. (a) 1-20-47 (b) W. E. Handley M.D.  
(Date received local registrar) (Registrar's signature)

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 Lynn H. Brown (M. D. or other) \_\_\_\_\_  
 Address 3112 Boonville Date signed 1/16/47

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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..... *Herbert V Smith*.....

Licensed Embalmer No..... *4286*.....

P. O. Address..... *Springfield, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9-21  
Registrar's No. 45

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

Henry Marshall

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 12 (Month) (Day) (Year)

8. AGE: Years 62 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

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

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-20-47 (Date received local registrar) (b) W. H. Handley and Co. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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

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

Major findings: Of operations \_\_\_\_\_

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) Accident  
(b) Date of occurrence About Nov. 17, 1946  
(c) Where did injury occur? on Franklin St. Springfield, Mo. (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? near his home on Franklin street  
While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature Leman D. Brown (M. D. or other) \_\_\_\_\_  
Address 311 1/2 Boonville Date signed Feb 20 47

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SUPPLEMENTARY

3-819