

S. No. 2
-12-45
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9258
Registrar's No. 1493

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town JACKSON
(c) Name of hospital or institution:
5312 CLEVELAND AVENUE 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 YEARS
In this community 22 YEARS
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town JACKSON 3
JACKSON
(If outside city or town limits, write "RURAL.")
(d) Street No. 5312 CLEVELAND AVENUE 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA MARSHALL
3. (b) If veteran, name war NO
3. (c) Social Security No. NO 101E

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MARCH day 28 1947 year. hour 3 minute 30 P M.
21. I hereby certify that I attended the deceased from 7/1/46 1946 to 3/28/47 1947.
that I last saw her alive on 3/28/47 1947 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife MR. JOHN Y. MARSHALL
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 5 1901
(Month) (Day) (Year)

Immediate cause of death Arterial hemorrhage Duration _____
Due to Carcinoma of the cervix - local metastases 2 yr.
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

8. AGE: Years 46 Months 0 Days 23 If less than one day _____ hr. _____ min.
9. Birthplace MT VIEW MISSOURI
(City, town, or county) (State or foreign country)
10. Usual occupation AT HOME

Major findings: None
Of operations None
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name WILEY CAMPBELL 1
13. Birthplace INDIANA
(City, town, or county) (State or foreign country)
14. Maiden name ROSE FOUTS
15. Birthplace NO. CAROLINA
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ursula Callen
(b) Address 1217 Brush Creek
17. (a) BURIAL (b) Date thereof 3-31-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. MORIAH CEMETERY
18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.
19. (a) 3-31-47 (b) Sheraldine Holmes
(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? 0
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature John C. Chalkley M. D. or other _____
Address 250 Ogden Bldg KC Mo Date signed 3/29/47

(Licensed Embalmer's Statement on Reverse Side)

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

836
2-4-30

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.....

D. J. Nozinger

Licensed Embalmer No. *3938*

P. O. Address *Kansas City, 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.