DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 7 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12089

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 23

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community Most of Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100 5

(c) City or town Sikeston 2 0 (If outside city or town limits, write "RURAL")

(d) Street No. North Stoddard (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Laura Marshall

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

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

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

7. Birth date of deceased Sept (Month) 9 (Day) 1872 (Year)

8. AGE: Years 74 Months 3 Days 29 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Franklyn Marshall
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Francis Carico
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Nephew Marvin Carall
(b) Address Sikeston Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Orville Taylor
(b) Address Sikeston Mo

19. (a) 3-29-47 (Date received local registrar) (b) Mrs I. F. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 8 year 47 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from 7-5-46, 1946 to 1-6-, 1947 that I last saw her alive on 1-6, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Cardiac Valvular disease	5 yrs
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) .....
(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 L. C. McClure (M. D. ~~or other~~)
Address Sikeston, Mo Date signed 5-21-47

505 (Licensed Embalmer's Statement on Reverse Side)

District Health Office N
District File Number 447-
Date Filed 4-3-4

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 James M. Scott

Licensed Embalmer No. 4350

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 233 Primary Registration District No. 3074 Registrar's No. 23

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Lana Marshall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife M

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

7. Birth date of deceased Sept. 9 (Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) 4/28-47 (Date received local registrar) (b) Mrs [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-12089