

FILED MAR 1 1948
324

Registration District No. **324**

Primary Registration District No. **3072**

1. PLACE OF DEATH:

(a) County **Saline**

(b) City or town **Marshall Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1475 South Redman
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **#**
(Specify whether)

In this community **All her life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline** **97**

(c) City or town **Marshall**
(If outside city or town limits, write "RURAL")

(d) Street No. **403 East Summitt**
(If rural, give location) **2**

(e) Citizen of foreign country? **No** (Yes or No) **3**
If yes, name country

3. (a) PRINT FULL NAME **Mrs. Minnie M. Clough**

3. (b) If veteran, name war **#**

3. (c) Social Security No. **#**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **8th**
year **1948** hour **11:00** minute **0** P. M.

4. Sex **F** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **W 2**

6. (b) Name of husband or wife **Robert Clough**

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

7. Birth date of deceased **November 17, 1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **2-2** 19**48** to **2-8** 19**48**
that I last saw **her** alive on **Feb 8** 19**48**
and that death occurred on the date and hour stated above.

8. AGE: Years **83** Months **2** Days **21**
If less than one day **br. min.**

Immediate cause of death **Respiratory failure**
Duration

9. Birthplace **Marshall, Missouri**
(City, town, or county) (State or foreign country)

Due to **Hypostatic pneumonia**

10. Usual occupation **Housewife**

Due to

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business **" "**

PHYSICIAN

12. Name **Richard B. Thorp**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

Major findings:
Of operations **|||**

Of autopsy

Underline the cause of which death should be charged statistically.

14. Maiden name **Julia Ann Marshall**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. A.T. Coffman**
(b) Address **Marshall, Missouri**

22. If death was due to external causes, fill in the following:

17. (a) **Burial** (b) Date thereof **2/10/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridge Park Cem.**

(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)

18. (a) Signature of funeral director **J. Leslie Sussing**
(b) Address **2240 W. Main St. Marshall, Mo.**

19. (a) **Feb-9-1948** (b) **Richard B. Thorp**
(Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (Specify type of place) Means of injury **0**

23. Signature **R. F. Wiken** (M. D. or other) **MD**
Address **Marshall Mo** Date signed **2-9-48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

2-3-48

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 _____

Marvin V. Newton

Registered Apprentice No. *51*

working under my personal supervision.

Signed _____

J. Leslie Sussung

Licensed Embalmer No. *32350*

P. O. Address _____

Marshall, 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.