

FILED JAN 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1956

BIRTH NO. _____ REG. DIST. NO. 233 PRIMARY REG. DIST. NO. 4348 Registrar's No. 3

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellsville</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wellsville</u> | |
| c. LENGTH OF STAY (in this place) <u>27 yrs</u> | | d. STREET ADDRESS (If rural, give location) <u>200 Kreckle St.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>200 Kreckle St.</u> | | d. STREET ADDRESS (If rural, give location) <u>200 Kreckle St.</u> | |

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|--|-------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>JOHN</u> c. (Last) <u>MARSHALL</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 16 1949</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u> | 8. DATE OF BIRTH <u>11-1-1857</u> | | 9. AGE (in years last birthday) <u>91</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (State or foreign country) <u>St Louis MO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |

| | | |
|--|--|--------------------------------------|
| 13a. FATHER'S NAME <u>B. B. Marshall</u> | 13b. MOTHER'S MAIDEN NAME <u>Lizzie Pigeon</u> | 14. NAME OF HUSBAND OR WIFE <u>-</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Frank K Leonard</u> | ADDRESS <u>Wellsville</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Myocarditis and Sympathetic degeneration</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>✓</u> | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>11/2</u> | | |

| | | |
|------------------------------|---|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>✓</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| | | |
|---|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Wellsville MO</u> |
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| | | |
|--|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|--|--|----------------------------------|

22. I hereby certify that I attended the deceased from July 1, 1948, to Jan 16, 1949, that I last saw the deceased alive on Jan 15, 1949, and that death occurred at 3 A. m., from the causes and on the date stated above.

| | | |
|---|-----------------------------------|---------------------------------|
| 23a. SIGNATURE <u>J. J. Byland M.D.</u> (Degree or title) | 23b. ADDRESS <u>Wellsville MO</u> | 23c. DATE SIGNED <u>1-17-49</u> |
|---|-----------------------------------|---------------------------------|

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|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11-18-1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Wellsville MO</u> |
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|---|--|------------------------------|
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Jan 17, 1949</u> <u>Shos. Meritt</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>F. W. Kuehne</u> | ADDRESS <u>Wellsville MO</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

JAN 27 1949

RECEIVED
District Health Officer No. 9,

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *W. K. Rubin*

Licensed Embalmer No. *3059*

P. O. Address *Wellsville 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.