

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39879

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 155

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SCOTT, MO.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston 0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston 0</u>	
c. LENGTH OF STAY (In this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>R-1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u>	b. (Middle) _____	c. (Last) <u>Marshall</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-21-49</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12-9-1903</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>FAYETTEVILLE, TENN.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Quinton Marshall</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZA Hill</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Isabella Marshall</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Pearl Hill</u>	ADDRESS <u>R-1, Sikeston</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>1.10X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>asthma</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last. - DUE TO (b) <u>Urinary retention</u> - DUE TO (c) <u>Chronic hypertrophic prostate</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from and Nov 17, 1949, to Nov 21, 1949, that I last saw the deceased alive on Nov 21, 1949, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm. C. Cutchlow M.D. II</u>	23b. ADDRESS <u>Sikeston</u>	23c. DATE SIGNED <u>Oct 27, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>11/23/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>	24d. LOCATION (City, town, or county) (State) <u>Blytheville Ark</u>
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DATE REC'D BY LOCAL REG. <u>Nov 23-49</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>	FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Welsh</u>	ADDRESS <u>Funeral Home Sikeston, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 28 1961  
District Health Office No. \_\_\_\_\_  
District File Number 1149  
Date Filed \_\_\_\_\_

**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 *Raymond Crews*

Licensed Embalmer No. 3467

P. O. Address *Sekeston 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.