

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40656**

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

BIRTH NO. _____ REG. DIST. NO. **P3** PRIMARY REG. DIST. NO. **4154** Registrar's No. **105**

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission). a. STATE MO b. COUNTY Dallas	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisburg, MO	
c. LENGTH OF STAY (in this place) 6 mo.		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION Smith Rest Home		4. DATE OF DEATH (Month) (Day) (Year) Nov - 30 - 1949	
3. NAME OF DECEASED (Type or Print) a. (First) Clyde	b. (Middle) Perry	c. (Last) Marsh	5. SEX M.
6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Apr. - 14 - 1897	9. AGE (In years last birthday) 52 IF UNDER 1 YEAR Months 7 Days 16 IF UNDER 1 YEAR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant	10b. KIND OF BUSINESS OR INDUSTRY Mercentile	11. BIRTHPLACE (State or foreign country) Dallas Co, MO	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Perry Marsh	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Maud Marsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mr. May Marsh ADDRESS Bellevue	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 _____	
19c. DATE OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 11-29 , 19 49 , to 11-29 , 19 49 , that I last saw the deceased alive on 11-29 , 19 49 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE W. D. Cowan (Degree or title) M.D.		23b. ADDRESS Greenfield Mo	23c. DATE SIGNED 11-30-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-2-49	24c. NAME OF CEMETERY OR CREMATORY Louisburg Cem	24d. LOCATION (City, town, or county) (State) Louisburg, MO
DATE REC'D BY LOCAL REG. Dec. 3-49	REGISTRAR'S SIGNATURE Geo. L. West	25. FUNERAL DIRECTOR'S SIGNATURE Vaughan-Rice ADDRESS Urbana, Mo	

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District Health Office No. 6,
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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

Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urban, 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.