

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED JAN 19 1953

BIRTH NO. _____ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 3072 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater	
c. LENGTH OF STAY (In this place) 4 days		d. STREET ADDRESS (If rural, give location) 624 Heiler St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbons Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude b. (Middle) Lee c. (Last) Marshall			4. DATE OF DEATH (Month) (Day) (Year) Jan. 15-1953		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH May, 16-1885		9. AGE (In years last birthday) 67		10. CITIZEN OF WHAT COUNTRY? U S	
10a. USUAL OCCUPATION (Give kind of work done during week of writing this form if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) New Franklin, Mo.	

13a. FATHER'S NAME Alonzo Settle		13b. MOTHER'S MAIDEN NAME don't know		14. NAME OF HUSBAND OR WIFE Roy A. Marshall	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Roy A. Marshall Slater, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		DUE TO (b) Essential Hypertension			Jan. - 11th	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Generalized Arteriosclerosis			4 Day	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			Years.	

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)	
21d. TIME OF INJURY		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, 1943, to Jan. 15, 1953 that I last saw the deceased alive on Jan. 14, 1953 and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. L. McBurney, M.D.		23b. ADDRESS Slater, Mo.		23c. DATE SIGNED 1/15/53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/17/1953		24c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery	
				24d. LOCATION (City, town, or county) (State) Moberly, Mo.	

DATE REC'D BY LOCAL REG. Jan 16 1953		REGISTRAR'S SIGNATURE D. L. McBurney		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Brothers, Slater, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater 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.