

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19942

State File No.

No. 300
10.48

FILED JUN 24 1954

REG. DIST. NO. 280 PRIMARY REG. DIST. NO. 6960 Registrar's No. 36

05 30

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

1. PLACE OF DEATH a. COUNTY PLATTE		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE MO b. COUNTY PLATTE	
b. CITY OR TOWN DEARBORN c. LENGTH OF STAY (in this place) 2		c. CITY OR TOWN DEARBORN <i>Green</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 6800	
3. NAME OF DECEASED: (First) SOPHIA (Middle) MARSH (Last) BOHANNON			4. DATE OF DEATH (Month) (Day) (Year) JUNE 14 - 1954
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB-16-1875
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) GENTRY Co. MO
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME SAMUEL W. MARSH		13b. MOTHER'S MAIDEN NAME TEMPA FERGUSON	14. NAME OF HUSBAND OR WIFE H.M. BOHANNON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME B.M. BOHANNON ADDRESS WYLSVILLE MO
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Lung & Liver		INTERVAL BETWEEN ONSET AND DEATH 2 years	
*This does not mean the mode of dying, such as heart failure, asphyxia, 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS 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) (Min.)	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 10-20, 1952 to 6-14, 1954 , that I last saw the deceased alive on 6-13, 1954 and that death occurred at 2:30 Am. , from the causes and on the date stated above.			
23a. SIGNATURE D. L. Durham M.D. (Degree or title)		23b. ADDRESS Dearborn, Mo.	23c. DATE SIGNED 6-14-54
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 6-14-1954	24c. NAME OF CEMETERY OR CREMATORY BERLIN	24d. LOCATION (City, town, or county) (State) KING CITY MO RFD.
DATE REC'D BY LOCAL REG. 6-14-54	REGISTRAR'S SIGNATURE Clifford R. Collins	25. FUNERAL DIRECTOR'S SIGNATURE Stelcher Funeral Home ADDRESS Waysville Mo	



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 _____

Licensed Embalmer No. 3960

P. O. Address Maysville 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.