

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2017

STATE FILE NUMBER

FILED JAN 21 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 18

Health, Welfare
Public
Service

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-56

Doctor, coroner, etc. must use only standard nomenclature in their reports - no symptoms written at random. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u> Length of stay in lb <u>1/6/57</u>		d. STREET ADDRESS (If outside, give location) <u>213 Terrace</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ELLIS</u> Last <u>MARSHALL</u>			4. DATE OF DEATH Month <u>January</u> Day <u>11</u> , Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1891</u>
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lasting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Shoe Company</u>	11. BIRTHPLACE (City and state or country) <u>Mexico Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>William Marshall</u>	
14. MOTHER'S MAIDEN NAME <u>Gharissa Weaver</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>490 07 5386</u>		17. INFORMANT <u>Mrs. W. E. Marshall</u> Address <u>Hannibal Missouri</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarct</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Lobar Pneumonia, acute</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>5 days</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1/6/1957</u> to <u>1/11/57</u> and last saw her/him alive on <u>1/11/1957</u> Death occurred at <u>4:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>B & L Building Hannibal, Mo.</u>	22c. DATE SIGNED <u>1/14/1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/14/1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
24. FUNERAL DIRECTOR'S ADDRESS <u>[Signature] Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1-15-57</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

99

RECEIVED JAN 18 1937

STANDARD CERTIFICATE OF DEATH

MARION CO. HEALTH DEPT.

DATE FILED JAN 18 1937

Registration District

RESIDENCE

STATE

Y
R
M

Y
R
M

Y
R
M

(Name of the decedent)

Y
R
M

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. Crawford Smith*

Licensed Embalmer No.....

P. O. Address Hannibal Mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.