

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013332

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 394

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-57

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| 1. PLACE OF DEATH a. COUNTY <i>Buchanan</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Buchanan</i> ⁰¹¹⁰ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i> | | c. CITY OR TOWN <i>Easton</i> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Meth. Hosp.</i> | | d. STREET ADDRESS (If outside, give location) <i>General Del.</i> | |
| Length of stay in lb <i>2 weeks</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>Williard</i> Last <i>Marshall</i> | | | 4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1958</i> |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 29, 1889</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | 9. AGE (In years last birthday) <i>68</i> |
| 11. BIRTHPLACE (City and state or country) <i>Craig, Mo</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13a. FATHER'S NAME <i>William F. Marshall</i> | | 13b. MOTHER'S MAIDEN NAME <i>Mary E. Hockman</i> | 14. NAME OF HUSBAND OR WIFE <i>Ardella Marshall</i> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | 17. INFORMANT Address <i>Ardella Marshall, Easton Mo</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> |
| Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <i>Amputation right leg 4501</i> | | | <i>48 hrs</i> |
| DUE TO (c) <i>Arteriosclerotic gangrene</i> | | | <i>3 mo</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arterio and atherosclerosis generalized</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 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 Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK AT <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 <i>Feb 1956</i> to <i>4-7-58</i> and last saw him alive on <i>4-7-58</i> Death occurred at <i>2:05 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>John P. Mabrey, M.D.</i> | | 22b. ADDRESS <i>Plattsburg, Mo.</i> | 22c. DATE SIGNED <i>4-10-58</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>4/9/58</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery St. Joseph, Mo</i> | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR <i>Supp. Funeral Home St. Joseph,</i> | | ADDRESS <i>Mo</i> | DATE RECD. BY LOCAL REG. <i>April 14, 1958</i> |
| 24. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i> | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *H. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.