

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033247

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 491

STATE FILE NUMBER

FILED OCT 10 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 3 Mo	c. CITY OR TOWN Kansas City Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3713 Hardy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4325 Moats Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE WINIFRED MARSHALL			4. DATE OF DEATH Month Day Year 9/27/61
5. SEX Fem	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1870
9. AGE (last birthday) 91		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Shelby Co., Mo
12. CITIZEN OF WHAT COUNTRY U S A		13a. FATHER'S NAME William Cochran	
13b. MOTHER'S MAIDEN NAME Martin		14. NAME OF HUSBAND OR WIFE Luther H. Marshall (Dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. no	17. INFORMANT Address Mrs. Katherine Cartella 4325 Moats Dr., K C Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterial Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of mouth.			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 20 yrs
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year			
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 April '55 to 9/13/61 and last saw ^{her} / _{him} alive on 9/23/61 Death occurred at 9/27/61 at 1:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. S. Regan, M.D. (Degree or title)		22b. ADDRESS Raytown, Mo	
22c. DATE SIGNED 9/29/61		23. NAME OF CEMETERY OR CREMATORY Memorial Park	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/30/61	
23c. LOCATION (City, town, or county) Kansas City, Mo		23d. (State)	
24. FUNERAL DIRECTOR Sheil Colonial Funeral Home, K C Mo		25. DATE RECD. BY LOCAL REG. 9-30-61	
26. REGISTRAR'S SIGNATURE Alba L. Craig			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

OCT 11 1961

STATEMENT BY LICENSED EMBALMER

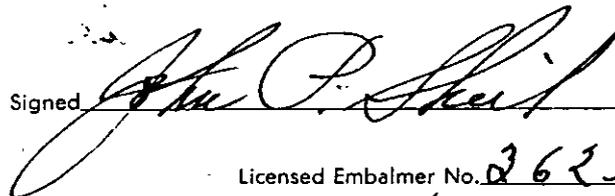
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 2625

P. O. Address K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.