

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**1986**  
Do not use this space.

1. PLACE OF DEATH *Boone*  
 (a) County *Boone* Registration District No. *73*  
 (b) Township \_\_\_\_\_ Primary Registration District No. *3006* Registered No. *8*  
 (c) City *Columbia* (d) Street No. *Mayes Hospital* St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *MARSHALL SAMS FRENCH 652*  
 (a) Residence, No. *1404 Bass Ave* St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>12-23-1927</i>		
7. AGE YEARS <i>10</i>	MONTHS <i>0</i>	DAYS <i>25</i>
		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>at Home</i>	
	9. Industry or business in which work was done, as saw mill, bank, etc. _____	
	10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Leavenworth, Iowa</i>		
FATHER	13. NAME <i>Joseph H. French</i>	
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Lancaster, Mo.</i>		
MOTHER	15. MAIDEN NAME <i>Moude Hutchinson</i>	
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Keokuk Iowa</i>		
17. INFORMANT (ADDRESS) <i>Joe B. French 1404 Bass Columbia Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Keokuk Iowa</i> DATE <i>1-20-1938</i>		
19. FUNERAL DIRECTOR (ADDRESS) <i>W.V. Whitesides 747 Furniture Co. Columbia Mo</i>		
20. FILED <i>1/19/1938</i> <i>Allie Selby</i> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 18 1938*

22. I HEREBY CERTIFY, that I attended deceased from *Jan 12 1938* to *Jan 18 1938*  
 (last saw him alive on *Jan 18 1938* Death is said to have occurred on the date stated above, at *2:00 am*.  
 The principal cause of death and related causes of importance were as follows:  
*Measles* Date of onset *Jan 12*

Other contributory causes of importance:  
*Stomach & Intestines*

**RECEIVED**

Name of operating physician \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? *FEB 21 1938* Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, at home, or in public place.

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Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *No*  
 If so, specify \_\_\_\_\_  
 (Signed) *R. J. Buehler*, M. D.  
 (Address) *Columbia Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*10*  
*430*

MAY 31 1949

STATEMENT BY LICENSED EMBALMER

I, W. W. Philetides, Licensed Embalmer No. 3893  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by W. W. Philetides  
L. E.  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.  
Signed W. W. Philetides  
Licensed Embalmer No. 3893

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.)