

REC'D OCT 5 1938

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

33399
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 7968
 (b) Township Marshall Primary Registration District No. 3038 Registered No. 137
 (c) City Marshall (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 464 Margaret St. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Mary J. Duggell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 21, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 8 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School Teacher
 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) Slater Mo

FATHER 13. NAME Joseph Davis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Elizabeth Davis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) A. Duggell (son) 464 Margaret St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Marshall DATE Oct 1, 1938

19. FUNERAL DIRECTOR (ADDRESS) Leslie Swaney Marshall Mo

20. FILED 9-29-38 Mary Kent Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28 38

22. I HEREBY CERTIFY, That I attended deceased from Sept 15 38 to Sept 28 38. I last saw him/her alive on Sept 27 38. Death is said to have occurred on the date stated above, at 7:30 A.M.

The principal cause of death and related causes of importance were as follows:

Paralysis, 1937

Other contributory causes of importance: Hypertension 1936

Name of operation _____ Date of _____
 What test confirmed diagnosis Clinical Was there an autopsy? no

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

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) Mary Kent, M. D.
 _____ (Address) Marshall 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.

82 D

STATEMENT BY LICENSED EMBALMER

I, J. Leslie Surrung, Licensed Embalmer No. 3235
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself
L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed J. Leslie Surrung
Licensed Embalmer No. 3235

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33399
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 196
(b) Township 7th Primary Registration District No. 30-38 Registered No. 137
(c) City Marshall (d) Street No. _____ 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

Laura Love Tzsell
(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 8 28

1. Hepaticalgia due to cerebral Neurinosis Date of onset 11/1/36
1936

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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 _____

Other contributory causes of importance:
Hypertension of 22

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 11/23 1938 W.K. Nick Local Registrar.
by M.J.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) L. P. Simmons, M. D.

(Address) Marshall Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

SUPPLEMENTARY

