

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16205  
Registrar's No. 71

AY 15 1940 796  
Registration District No. 796

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(c) Name of hospital or institution: 796 W. Jackson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Saline  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. 796 W Jackson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26  
year 1940 hour 12:00 minute Noon M.  
21. I hereby certify that I attended the deceased from Nov 1  
1940 to Apr 26, 1940  
that I last saw him alive on Apr 25, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma  
Due to Struck 540  
Due to \_\_\_\_\_  
Other conditions none 46  
(Include pregnancy within 3 months of death)

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME EARL CLAUSS 420  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years

7. Birth date of deceased Dec 5 1894  
(Month) (Day) (Year)

8. AGE: Years 45 Months 4 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saline Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name H. H. Claus  
13. Birthplace MO  
(City, town, or county) (State or foreign country)

14. Maiden name Hennetta Samuels  
15. Birthplace Sheridan Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. Santa Claus  
(b) Address Marshall MO

17. (a) Burial (b) Date thereof 4-28-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Lick  
18. (a) Signature of funeral director Harry Hershberger  
(b) Address Marshall MO

19. (a) 4-27-40 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 712  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature M. H. Hershberger (M. D. or other) \_\_\_\_\_  
Address Marshall Mo Date signed 4-27-40

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.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 5-14-40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Felix Benz

Licensed Embalmer No. H127

P. O. Address Marshall, 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 this body is not embalmed, above space should be left blank.**