

WHILE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Russell  
Township Carroll  
or Carroll  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 739 File No. 11698  
Primary Registration District No. 4441 Registered No. \_\_\_\_\_

FULL NAME

James R Marshall

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)

DATE OF BIRTH March 9 1916  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. 1 mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Carroll Mo.

PARENTS

NAME OF FATHER J. S. Marshall

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.

MAIDEN NAME OF MOTHER Alice Paul

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Carroll Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. S. Marshall  
Carroll Mo.  
(ADDRESS)

Filed 3-10 1916 W. H. Burger  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 10 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 10:30 p.m., 1916, to 11:00 p.m., 1916, that I last saw him alive on 3-10-16, 1916, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

Unnatural death  
71 81.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.  
March 10 1916 (Address) Carroll Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Carroll Mo. DATE OF BURIAL 3-11 1916

UNDERTAKER W. H. Burger ADDRESS \_\_\_\_\_  
W. H.

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

**PLACE OF DEATH**

County \_\_\_\_\_

Township \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_

or Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

or City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_

COLOR OR RACE \_\_\_\_\_

SINGLE MARRIED WIDOWED OR DIVORCED (Put in the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

**PARENTS**

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_