

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

38783  
Do not use this space.

**NOV 23 1937**

1. PLACE OF DEATH  
 (a) County ST. LOUIS Registration District No. 789  
 (b) Township NORMANDY Primary Registration District No. 6033C  
 (c) City OVERLAND (d) Street No. 2234 S. WISE 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 JOHN SYLVESTER MARSHALL  
 (a) Residence, No. 2234 SWISE 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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF HELEN KINCAID MARSHALL

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC. 5, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
60 9 23

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED  
 9. Industry or business in which work was done, as saw mill, bank, etc. PLUMBER  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 34 YRS.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO

FATHER  
 13. NAME JOSEPH A. MARSHALL  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND

MOTHER  
 15. MAIDEN NAME MARY Q. MALONEY  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND

17. INFORMANT (ADDRESS) HELEN KINCAID MARSHALL  
2234 S. WISE, OVERLAND, MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE lake CHARLES DATE Oct 2 - 1937

19. FUNERAL DIRECTOR (ADDRESS) Baumman Bros and Co Inc  
2504 Woodson, OVERLAND, Mo.

20. FILED 10-1-37 Adal Bachner  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT. 28, 1937

22. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1937 to Sept 28, 1937  
 I last saw him alive on Sept 28, 1937. Death is said to have occurred on the date stated above, at 5:15 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Nephritis  
 Date of onset Sept 26, 1937

Other contributory causes of importance:  
Arenia  
 Date of onset Sept 27, 1937

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chemical 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? No.  
 If so, specify \_\_\_\_\_  
 (Signed) Norman J. Kleckner, M. D.  
 (Address) 9621 Backland Rd.

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.

82a

STATEMENT BY LICENSED EMBALMER

I, Oscar J. Mueller, Licensed Embalmer No. 3039

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. 3039 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Oscar J. Mueller

Licensed Embalmer No. 3039

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.)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
BUREAU OF HEALTH SERVICES  
STATEMENT BY LICENSED EMBALMER

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

38783  
Do not use this space.

1. PLACE OF DEATH

(a) County St Louis Registration District No. 789  
(b) Township \_\_\_\_\_ Primary Registration District No. 6033 C Registered No. \_\_\_\_\_  
(c) City Overland (d) Street No. \_\_\_\_\_  
(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

John Sylvester Marshall  
(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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28, 1937

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.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60 9 23

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

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

Left Cerebral Hemorrhage

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

131  
Other contributory causes of importance:  
menia, due to chronic nephritis

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar

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) Herman J. Kloeckner, M. D.

(Address) 9621 Sackland Rd.

Every death certificate should be carefully checked. 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.

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

SUPPLEMENTARY

