

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

JAN 12 1940

791
1003

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41688

Registrar's No. 10811

Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 2
(b) City or town ST. LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 1
(c) City or town ST. LOUIS 5
(If outside city or town limits, write "RURAL")
(d) Street No. 6023 WATERMAN AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME EDWARD G. MARSH SR. 620

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, MARRIED

6. (b) Name of husband or wife MARGARET C. MARSH 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased February 15, 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>10</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation INSPECTOR TREASURY DEPT. U. S. GOVERNMENT

11. Industry or business _____

MOTHER FATHER { 12. Name CHARLES MARSH

13. Birthplace MASS.
(City, town, or county) (State or foreign country)

14. Maiden name MARY FOSTER
(City, town, or county) (State or foreign country)

15. Birthplace ENGLAND
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Margauth Marshall

(b) Address 6023 WATERMAN AVE.

17. (a) BURIAL (b) Date thereof 12-20-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 LINDELL BLVD.

19. (a) DEC 18 1939 (b) J. B. Budick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 17,
year 1939 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 14th
to Dec 17, 1939
that I last saw him alive on Dec 17, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death
Congestive Heart Failure
Hypertensive Cardio-Vascular Disease
Due to _____
Duration 3 days

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: none
Of operations none
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Arthur J. Donnelly (M. D. or other) _____
Address 415 Beaumont Bldg Date signed 12/18/39

372066
J. H. 5100

288-5308

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lundell

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.