

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4359

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution: 3301 Olive St 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
 (Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME Walter Owens Marsden 623

8. (b) If veteran, name war Unknown
 8. (c) Social Security No. 494-10-7718

4. Sex Male
 5. Color or race White
 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 Unknown
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 55 hr. min.

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

10. Usual occupation Clerk

11. Industry or business _____

12. Name Unknown

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

14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W H Shuckefer

(b) Address 3903 Olive St

17. (a) Burial (b) Date thereof May 16 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Petz Brothers

(b) Address 3029 Lafayette Ave

19. (a) MAY 16 1940 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3301 Olive St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day May
 year 1940 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from May 31
1929, to May 11, 1940
 that I last saw him alive on May 11, 1940:
 and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis (chronic) Duration _____

Due to _____
 Due to _____

Other conditions lung lutea acutis
Chr int nephritis
 (Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury 1

23. Signature W H Shuckefer (M. D. or other) _____
 Address 3903 Olive Date signed May 16

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

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.

Dr. H. H. H. H. H.

Dr. 5/28

10 a.m.

Walter B. B. B.

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 *Frank J. Jones*.....

Licensed Embalmer No. *2218*.....

P. O. Address *St. Louis, 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.