

S. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 34062
Registrar's No. 8759

NOV 16 1940

791

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days |
(Specify whether _____)
In this community 30 yrs
years, months or days)

3. (a) PRINT FULL NAME Thomas Marmon

3. (b) If veteran, name war _____ 3. (c) Social Security No. unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 5 1899
(Month) (Day) (Year)

8. AGE: Years 41 Months 10 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer
W. P. A

11. Industry or business _____
12. Name Thomas Marmon

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

14. Maiden name Georgia Marmon
(City, town, or county) (State or foreign country)

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

16. (a) Informant Georgia Marmon
(b) Address 402 57th St. Enright Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 40
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery
18. (a) Signature of funeral director Atkins Bros
(b) Address 3644 Farmway Ave

19. (a) OCT 24 1940 (b) [Signature]
(Date observed) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St Louis |
(If outside city or town limits write "RURAL")
(d) Street No. 4257 R Enright
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1940 hour 2:30 minute PM

21. I hereby certify that I attended the deceased from Oct 10, 1940, to Oct 19, 1940, that I last saw him AM alive on Oct 19, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute tuberculous Pneumonia Duration 4 wks

Due to _____
Due to _____

Other conditions _____
(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 _____
23. Signature [Signature] (M. D. or other) _____
Address 2601 N Whittier Date signed 10/21/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed

Louis V. Atkins

Licensed Embalmer No. *2842*

P.O. Address *3644 Finney*

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.