

No. 2
1-5-42
5-17-39
X52873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28718

FILED OCT 14 1948 18

1003

State File No.

Registrar's No. 8224

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:
11 So. Spring Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community **24 Years.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town **St. Louis.**
(If outside city or town limits, write "RURAL")
(d) Street No. **718 No. Vandeventer Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **3.**
year **1942** hour **5** minute **50** A.M.
21. I hereby certify that I attended the deceased from **10-9-11**
19. to **10-3-42** 19. **42**
that I last saw **er** alive on **10-2-42** 19. **42**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Myocarditis, chronic

Due to **Coronary Sclerosis**

Other conditions.....
None

Major findings:
Of operations **None**
Of autopsy **None**

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?

(Specify type of place) (Specify type of place)
While at work..... Means of injury.....
23. Signature **Philip Schuck** (M.D. or other).....
Address **1703 18th Street** Date signed **10-3-42**

3. (a) PRINT FULL NAME **Marjorie Forman.**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F.** / 5. Color or race **W.** / 6. (a) Single, widowed, married, divorced **Married.**

6. (b) Name of husband or wife **Frank Forman.** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **January 1, 1900**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	42	9	2	hr. min.

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

10. Usual occupation **Housewife.**

11. Industry or business.....

12. Name **Robert Charles Sherrell.**

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

14. Maiden name **Ada McGrow.**
Mo.

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

16. (a) Informant **Mr. Frank Forman.**

(b) Address **718 No. Vandventer Ave.**

17. (a) **Burial.** (b) Date thereof **10-5-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Pickers Cemetery**

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

(b) Address **3540 Lindell Blvd**

19. (a) **OCT 5 1942** (b) **J. F. Brudack**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

17035061
J. Marshall

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 Kinnell

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, fact should be so stated above.