

JUN 4 1943

1003

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **4712**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution:  
**2405 N. Vandeventer /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

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. **2405 N. Vandeventer**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Michael J. Marshall**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **20**  
year **1943** hour **2** minute **50a.M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Mary Fogarty**  
6. (c) Age of husband or wife if alive **72** years  
7. Birth date of deceased **November 15 1868**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 16**  
**1943** to **Friday 20**, 19**43**  
that I last saw **him** alive on **May 19**, 19**43**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**74** **6** **5** hr. min.

Immediate cause of death **Acute Uræmia**  
Duration **2 days**

9. Birthplace **Co. Limrick Ireland 4**  
(City, town, or county) (State or foreign country)

Due to **Chronic Parenchymatous Nephritis**  
Due to \_\_\_\_\_

10. Usual occupation **Odd Job Contractor**  
11. Industry or business \_\_\_\_\_  
12. Name **Michael Marshall**  
13. Birthplace **Co. Limrick Ireland 4**  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations **1/21**  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

14. Maiden name **Mary Hayes**  
15. Birthplace **Co. Limrick Ireland 4**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Clarence Marshall**  
(b) Address **2405 N. Vandeventer Ave.**

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? \_\_\_\_\_

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-22-43**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**  
18. (a) Signature of funeral director **Cullinane Bros.**  
(b) Address **1710 N. Grand Blvd.**  
19. (a) **MAY 21 1943** **J. F. Budick**  
(Date received local registrar's certificate) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature **C. C. Emerson** (M. D. or other) \_\_\_\_\_  
Address **3870 Easton** Date signed **May 20**

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

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Fred Frick*

Licensed Embalmer No. 3186

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, fact should be so stated above.**