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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30961**

FILED OCT 13 1943 **318**

Primary Registration District No. **1003**

Registrar's No. **8635**

1. PLACE OF DEATH:
(a) County St. Louis Missouri
(b) City or town _____
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 25 mo
(c) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. Pine Hotel - 824 - Pine St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Marshall James
3. (b) If veteran, name war Unknown 3. (c) Social Security No. ----

4. Sex Male 0 5. Color or race White
6. (a) Single, widowed, married, divorced, single
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 2nd, 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>3</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business Unknown

MOTHER FATHER

12. Name Wm. Marshall
13. Birthplace ?
(City, town, or county; (State or foreign country)
14. Maiden name Mary Marshall
15. Birthplace ?
(City, town, or county; (State or foreign country)

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Autonomal Board Date thereof Sept 9, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington D.

18. (a) Signature of funeral director W. K. ...

(b) Address 3506 ...

19. (a) SEP 9 1943 (b) J. F. Budek
(Date received local health department) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th
year 1943 hour 8:05 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 8th 1943 to Sept. 5th 1943
that I last saw him alive on Sept. 5th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory and Respiratory failure

Due to Subarachnoid hemorrhage 7 days?

Due to _____

Other conditions. (Include pregnancy within 3 months of death) 82

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 Robert E. Holt (M. D. or other) _____
Address 1515 Lafayette Date signed 9/7/43

Duration 2 hrs.?
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.