

No. 2
4-2-43
5-17
I

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32568/

State File No. _____

FILED SEP 21 1943 317

Registration District No. _____

Primary Registration District No. 3069

Registrar's No. 2057

1. PLACE OF DEATH: St. Louis

(a) County Richmond Heights

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0
(Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 770 Bayard Ave. 9
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 1

3. (a) PRINT FULL NAME Elle Markle

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Millard Markle

6. (c) Age of husband or wife if alive 12 years 1865

7. Birth date of deceased: July 12 1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days X
If less than one day _____ hr. _____ min.

9. Birthplace: Detroit Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown Lindsey

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

14. Maiden name Lucinda Lindsey

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

16. (a) Informant L.B. Markle

(b) Address 770 Bayard Ave,

17. (a) Burial (b) Date thereof 9/14/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd.

19. (a) 9-14-43 (b) E. G. Mc Gowan, Jr.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1943 hour 10 AM minute 2nd A. M.

21. I hereby certify that I attended the deceased from 1942 - _____, 19____, to _____, 19____;

that I last saw h. er alive on Sept. 12, 1943;

and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction
Duration 36 hrs

Due to _____

Due to _____

Other conditions Sensibility
(Include pregnancy within 3 months of death)

Major findings: Of operations Intestinal Obstruction

Of autopsy Intestinal Obstruction

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

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)

23. Signature W. H. Hovington (M. D. or other) _____

Address 3831 Market St Date signed 9/17/43

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..... *J. Allen Davis Jr.*
Licensed Embalmer No. *4053*
P. O. Address *City*

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.