

S. No. 2  
M-5-43  
7. 5-17-39  
I X36671

#38474  
FILED FEB 24 1945

318

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

1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 4 days Memorial  
(Specify whether)

In this community \_\_\_\_\_  
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. 1212 Lynch Str.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elmer Marshall

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 493-10-9865

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

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

7. Birth date of deceased Mar. 9, 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 11 28 hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7th year 1945 hour 4:10 minute Am.

21. I hereby certify that I attended the deceased from 2/3/45 to 2/7/45, 19\_\_\_\_, to 2/7/45, 19\_\_\_\_; that I last saw him alive on 2/7/45, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death  
Sephitic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 30

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Refused

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

9. Birthplace Chester Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Motorman

11. Industry or business Street Railway

MOTHER FATHER { 12. Name Robert Marshall

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

14. Maiden name Elizabeth ?

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

16. (a) Informant Marie Marshall

(b) Address 1212 Lynch Str.

17. (a) Burial (b) Date thereof 2/10/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director Wm. C. Moydell

(b) Address 1926 Allen Ave.

19. (a) FEB 8 1945 (b) J. F. Bredich  
(Date received local registrar) (Registrar's signature)

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)

(a) Means of Injury \_\_\_\_\_

23. Signature James Stewart (M. D. or other) \_\_\_\_\_

Address 1515 Lafayette signed 2/7/45

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 me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed D M Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen Ave

**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.