

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

FILED MAR 26 1945  
Registration District No. 3063

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton

(c) Name of hospital or institution: St. Louis County Hospital  
(If outside city or town limits, write "RURAL" and name of township)

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

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Joseph P. Marxer

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Meta C. Marxer nee Jost

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased January 5, 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>2</u>	<u>1</u>	hr. min.

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

10. Usual occupation Baker

11. Industry or business Retired

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Meta C. Marxer

(b) Address 9979 Valley Dr. Riverview Gds

17. (a) Burial (b) Date thereof March 9 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Avenue A.O.

19. (a) MAR 8 1945 (b) E. G. B. ... M.D. E.P.H.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Riverview Gardens 91  
(If outside city or town limits, write "RURAL")

(d) Street No. 9979 Valley Dr. 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th  
year 1945 hour 9:30 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death Bullet wound in Skull Duration \_\_\_\_\_

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

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

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

Major findings: 169c  
Of operations \_\_\_\_\_

Physician \_\_\_\_\_

Underline the cause to which death should be charged statistically.

of autopsy Bullet Wound in skull

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence March 6th 1945.

(c) Where did injury occur? Riverview Gdns.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Arnold J. Williams (M.D. or coroner)  
Address Clayton, Mo. Date signed 3-8-45

**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

*Gustav W. Dautule*

Licensed Embalmer No.

*4329*

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.**