S. No. 2
M—2-43
. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 21 1945

State File No. 29234

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7976

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
2315 McLaren Str., /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair 999

(c) City or town East St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 1826 Cleveland NR
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Earl W. Marshall

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced ~~Widowed~~ /

6. (b) Name of husband or wife ~~Ettie E.~~ Gussie Marshall

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

7. Birth date of deceased March (Month) 25 (Day) 1881 (Year)

8. AGE: Years 64 Months 5 Days 13 If less than one day hr. min.

9. Birthplace Stuncer Co., (City, town, or county) Indiana in/ (State or foreign country)

10. Usual occupation Salesman Co.

11. Industry or business Gen'l Sales & Engineering

FATHER
12. Name Simon Marshall
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Michael J Mangrum
(b) Address 2315 McLaren Jennings 21, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-8-45 (Month) (Day) (Year)
(c) Place: ~~burial or cremation~~ E. St. Louis, Ill.

18. (a) Signature of funeral director [signature]
(b) Address E. St. Louis, Ill.

19. (a) SEP 12 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 8 year 1945 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from 6-16, 45, to 9-8, 45; that I last saw him alive on 9-8, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	2 days
Due to tertiary syphilis	35 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death) 30	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) DO
Address 2810 a W. Florissant Date signed 9-10-45

(Licensed Embalmer's Statement on Reverse Side)

OCT 34 1945

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. 3162

P. O. Address E St Louis Ill

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.