

FILED NOV 21 1945
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Registration District No. _____ Primary Registration District No. 1003

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

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:
4544 Westminster Ave. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Sylvester Samuel Marshall
 3. (b) If veteran, name war World War 1
 3. (c) Social Security No. 487-24-6058

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lucille Marshall
 6. (c) Age of husband or wife if alive 44 years
 7. Birth date of deceased November 8 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 11 12 hr. _____ min.

9. Birthplace Dighton Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Hotel Auditor
 11. Industry or business Gatesworth Hotel

12. Name John A. Marshall
 13. Birthplace Fountain County Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Ellen Guyer
 15. Birthplace Henry County Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Lucille Marshall
 (b) Address 4544 Westminster Ave.

17. (a) Burial (b) Date thereof 10-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) OCT 23 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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. 4544 Westminster Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20
 year 1945 hour 6 minutes 55 M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Protein Myocarditis (Fibrous)
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 8 months of death)

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? _____

23. Signature Patrick E. Day (e) Means of injury _____
(M. D. or other)
 Address Dep. coroner Date signed 10/23/45

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

DEC 13 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 W. W. Wilkinson

Licensed Embalmer No. 35-75

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.