DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39494

FILED JAN 5 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11171

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

1. PLACE OF DEATH:
(a) County St Louis Mo.
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1712 N. Whittier St. 1
(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 MISSOURI (b) County
(c) City or town St Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 1712 N. Whittier
(If rural, give location)
(e) Citizen of foreign country? D (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANK MACKLIN
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex Male 2
5. Color or race Col.
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Elizabeth Macklin
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 1 (Day) 1888 (Year)

8. AGE: Years 57 Months 9 Days 16 If less than one day hr. min.

9. Birthplace BROWN VILLIE TENN. 1
(City, town, or county) (State or foreign country)
10. Usual occupation LABOR
11. Industry or business FOUNDRY
FATHER
12. Name JERRY MACKLIN
13. Birthplace TENN. 1
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name SALLIE MACKLIN
15. Birthplace TENN. 1
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Elizabeth Macklin
(b) Address 1712 N. Whittier St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Herman Smith
(b) Address 4247 McLaughlin Ave
19. (a) DEC 20 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17 / 1945
year 5 hour 15 minute p. M.
21. I hereby certify that I attended the deceased from 10/18, 1945, to 12/17, 1945
that I last saw him alive on 12/17/45, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Disease
Due to
Due to Hypertension
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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 D
23. Signature Leo Comissiong (M. D. or other)
Address 1701 Whittier Date signed 12/20/45

(Licensed Embalmer's Statement on Reverse Side)

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 Lawrence E Wadsworth

Licensed Embalmer No. 4341

P. O. Address 443 Garfield

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.

St Louis, 3 Mo

S. No. 2D
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11171

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:

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank Marklin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 59 years

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

8. AGE: Years 57 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) JAN 17 1945 (Date received by local registrar) (b) J. F. Bedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 17 year 1943 hour minute 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

39494