

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

42467

Registrar's No.

2916

Registration District No. 252 29 1945

Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Marys Hospital 0  
(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

3. (a) PRINT FULL NAME Boulah Belle Marmion

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widow ?

6. (b) Name of husband or wife James R. Marmion

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

7. Birth date of deceased Sept. 27th, 1875  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	3	5	hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business Not employed

12. Name Alonza Erwin

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

14. Maiden name Dora Unknown

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

16. (a) Informant H. M. Baty

(b) Address 6655 Berthold Ave

17. (a) Cremation (b) Date thereof 12/23/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Chapel

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) 12-26-45 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County 999

(c) City or town San Antonio H/1  
(If outside city or town limits, write "RURAL")

(d) Street No. 222 Cloverleaf 1  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 22nd  
year 1945 hour 9.15 minute A M.

21. I hereby certify that I attended the deceased from 12/20/45, 19\_\_\_\_, to 12/22/45, 19\_\_\_\_;  
that I last saw her alive on 12/22/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary thrombosis

Due to Arteriosclerosis

Due to 94a

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Of autopsy No 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? \_\_\_\_\_

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

(e) Means of injury [Signature]

23. Signature [Signature] (M. D. or M.P.S.) [Signature]

Address 6311 N. Grand Blvd Date signed 12/23/45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MAR 18 1946

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**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.....

.....  
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.**