

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED MAR 16 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10765**
Registrar's No. **627**

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Kochs
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 37 months
(Specify whether years, months or days) 20 yrs

3. (a) PRINT FULL NAME Marshall W Jenkins

3. (b) If veteran, name war - 3. (c) Social Security No. 493-10-1923

4. Sex M 5. Color or race Negri 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 27 years 46

7. Birth date of deceased (Month) 36 (Day) 27 (Year) 1901

8. AGE: Years 44 Months 9 Days 16 If less than one day hr. min.

9. Birthplace Boliver Co Miss (City, town, or county) (State or foreign country)

10. Usual occupation Pin boy

11. Industry or business

12. Name Sam Jenkins

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

14. Maiden name Susie Lee

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital, Koch, Mo

17. (a) Removal (b) Date thereof 3-15-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation C. A. Law

18. (a) Signature of funeral director C. J. Mack
(b) Address 1177 1/2 3rd

19. (a) 3-15-46 (b) Ed M. Sauer MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County - (c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 14389 N. Jefferson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 13
year 46 hour 12 minute 18 P. M.

21. I hereby certify that I attended the deceased from 8
13 1943 to 3-13- 1946

that I last saw him alive on 3-13- 1946
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis Duration 4 yrs(?)

Due to 135

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?

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

23. Signature Raymond Friedman MD M. D. or other MD
Address Robert Koch Hospital Koch, Mo Date signed 3-14-46

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

76
0
R

5077

707

(Licensed Embalmer's Statement on Reverse Side)

MAR 29 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.....

M. James Nash, Registered Apprentice No. *394*
working under my personal supervision.

Signed *C. J. Nash*

Licensed Embalmer No. *2482*

P. O. Address *111 N. 13th St.*

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.