

No. 2  
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-17-39  
X37823

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19131**  
Registrar's No. **4972**

Registration District No. **318** Primary Registration District No. **1003**

**1. PLACE OF DEATH:**  
 (a) County St. Louis Mo.  
 (b) City or town St. Louis Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: DePaul Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 months  
 (Specify whether years, months or days) 15 years

**3. (a) PRINT FULL NAME** Virginia Marchbanks  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or white  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept 6, 1926  
 (Month) (Day) (Year)

**8. AGE:** Years 20 Months 8 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation clerk

11. Industry or business self

12. Name Curtis Marchbanks

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

14. Maiden name Bertie Abbott

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

16. (a) Informant Mrs. B. Abbott  
 (b) Address 4151 Maffitt

17. (a) Burial (b) Date thereof 5/17/47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Joseph A. Howard  
 (b) Address 1619 So. Grand

19. (a) MAY 16 1947 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo. (b) County oao  
 (c) City or town St. Louis 17  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4151 Maffitt 9  
 (If rural, give location) 1  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 15  
 year 1947 hour 9:00 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from March 3  
1947, to May 15, 1947  
 that I last saw her alive on May 15, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Sarcoma  
generalized metastases  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 55

Duration

**PHYSICIAN**

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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? \_\_\_\_\_

What at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 0

23. Signature Cl Wornas (M. D. or other) \_\_\_\_\_  
 Address 5391 Grand Date signed 5/16/47

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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..... *G. W. Wilkinson*

Licensed Embalmer No..... *3575*

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.**