

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13974**
 BIRTH NO. **49-025173** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1008** Registrar's No. **3858**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 2238 Franklin
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips					
3. NAME OF DECEASED (Type or Print) Maureen			a. (First)	b. (Middle)	c. (Last) Marshall
4. DATE OF DEATH (Month) (Day) (Year) 4 15 49					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) U	8. DATE OF BIRTH 4-15-49	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 1
IF UNDER 24 HRS. Hours 1	IF UNDER 2 HRS. Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME Lonnie Marshall		13b. MOTHER'S MAIDEN NAME Donna Thompson		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Arthur M. Sheward		ADDRESS R.R. 2601 N. Whittier	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES				
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
	DUE TO (b)				
	DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 159			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X			
22. I hereby certify that I attended the deceased from 4-14- , 19 49 , to 4-15- , 19 49 , that I last saw the deceased alive on 4-15- , 19 49 , and that death occurred at 5:20pm. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) W. S. Shields			23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 4-20-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE APR 30 1949	24c. NAME OF CEMETERY OR HOSPITAL ANDREW LEONARD HOSPITAL	24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. APR 30 1949	REGISTRAR'S SIGNATURE J. B. Frontier		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service 4104 Manchester Ave.		

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

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_____

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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.