

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25096

State File No. 6429

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>40 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2310<sup>e</sup> So. BROADWAY</b>				d. STREET ADDRESS (If rural, give location) <b>23 - 2310<sup>e</sup> So. BROADWAY</b>			
3. NAME OF DECEASED (Type or Print) <b>GUSS</b>		a. (First)		b. (Middle)		c. (Last) <b>MARMON</b>	
4. DATE OF DEATH <b>July 22 - 1949</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	
8. DATE OF BIRTH <b>MAY 17 - 1874</b>		9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>		IF UNDER 1 HR. Hour <b>5</b> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILL WORKER</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Carrollton, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <b>JOHN MARMON</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH WINN</b>		14. NAME OF HUSBAND OR WIFE <b>EFFIE (ROBA)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NIL</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>EFFIE MARMON</b>		ADDRESS <b>2310<sup>e</sup> So BROADWAY</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic Pneumonia</b> ANTECEDENT CAUSES <b>Cerebral Hemorrhage (Paralysis)</b> 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. _____				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>1 year</b>	
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) <b>M</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>Mo</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>331X</b>					
22. I hereby certify that I attended the deceased from <b>July 18, 1949</b> , to <b>July 22, 1949</b> , that I last saw the deceased alive on <b>July 19, 1949</b> , and that death occurred at <b>11:15 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>H. C. Fritschel M.D.</b> (Degree or title)				23b. ADDRESS <b>3306 So 13<sup>th</sup> St. Louis Mo</b>		23c. DATE SIGNED <b>7/23/49</b>	
24a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7-25-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL <b>JUL 25 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lascara</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Allen W. McLaughlin</b>		ADDRESS <b>2301 Lafayette</b>	

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.

Student .....  
Student Embalmer

Signed.....

*C W Cooper*

Licensed Embalmer No. *9830*

P. O. Address *2301 Lafayette*

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.