

FILED JUL 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21793
State File No. 5294
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO b. COUNTY MO

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (In this place)
OR TOWN ST LOUIS 1-MONTH
c. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN WELLSTON 4300

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location)
DE PAUL HOSP. 2415 N. KING
50. STREET ADDRESS (If rural, give location)
ST VINCENT'S. SAM- 7300 ST CHARLES Rock RO.

3. NAME OF DECEASED a. (First) SISTER b. (Middle) CAROLINE c. (Last) MARMION
(Type or Print) 4. DATE OF DEATH (Month) (Day) (Year)
June 15 1950

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 8. DATE OF BIRTH OCT 13- 1882
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) SAN FRANCISCO CALIF. 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME ROBERT MARMION 13b. MOTHER'S, MAIDEN NAME CAROLINE VOORHIES 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 ST. MARY-VINCENT-ST. Vincent's San Wellston
(If yes, give war or dates of service) ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intellectual Obstruction INTERVAL BETWEEN ONSET AND DEATH 10 days
ANTECEDENT CAUSES Carcinoma of sigmoid
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
Morbidity 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 NO

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) _____

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 152X

22. I hereby certify that I attended the deceased from May 15 1950, to June 15 1950, that I last saw the deceased alive on June 14 1950, and that death occurred at 10:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D. 23b. ADDRESS 539 N. Grand Blk. St. Louis Mo. 23c. DATE SIGNED 6/15/50

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 6-17-50 24c. NAME OF CEMETERY OR CREMATORY MARRILLAC 24d. LOCATION (City, town, or county) (State) NORMANDY MO

DATE REC'D BY LOCAL REG. JUN 16 1950 REGISTRAR'S SIGNATURE J. B. Fasater 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen-Kelly 7267 North Bridge

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 James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St Louis Mo.

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. I I I R A A N