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8315

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Township</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>518 Delmar</b>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Percy</b>	b. (Middle)	c. (Last) <b>Marriage</b>	4. DATE OF DEATH (Month) (Day) (Year)
				<b>Sept 19 51</b>

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Apr 9, 1876</b>	9. AGE (In years last birthday) <b>75</b>	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 MIN. Hours	13. UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>self employed</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>rug manufacturer</b>	11. BIRTHPLACE (State or foreign country) <b>unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth Marriage</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Aline Marriage, Barnhart, Mo.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Left Bundle Branch Block</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes Mellitus</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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>H33.0</b>
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22. I hereby certify that I attended the deceased from **9-5, 1951**, to **9-19, 1951**, that I last saw the deceased alive on **9-19, 1951**, and that death occurred at **4 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>P. D. Hengel M.D. Ch</b>	23b. ADDRESS <b>462 Mo. Taylor</b>	23c. DATE SIGNED <b>9/20/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>9/20/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Big Lake Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Big Lake, Minn.</b>
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DATE REC'D BY LOCAL REG. <b>SFP 20 1951</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rowland Mortuary Service</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10. 38

FILED OCT 10 1951

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 \_\_\_\_\_  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed.....  
Student Embalmer No. ....  
Licensed Embalmer No. 4366  
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.