

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **3469**
 Registrar's No. **0175**

LEO JAN 28 1953

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3973 W Bell	

3. NAME OF DECEASED (Type or Print) Doc			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Jan. 5 1953		
5. SEX Male	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG. 25, 1901			9. AGE (In years last birthday)	10. MONTHS	11. DAYS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) TAMPA, FLORIDA		

13a. FATHER'S NAME HENRY MARSHALL	13b. MOTHER'S MAIDEN NAME LAURA ?	14. NAME OF HUSBAND OR WIFE BESSIE MARSHALL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME Bessie Marshall
		ADDRESS 3973 W. Belle

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Congestion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Old Myocardial Infarct DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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? 4/20.K

22. I hereby certify that I attended the deceased from **1-2**, 19**53**, to **1-5**, 19**53**, that I last saw the deceased alive on **1-5**, 19**53** and that death occurred at **8:20a** m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Edward B. Williams		23b. ADDRESS 2601 N. Whittier St	23c. DATE SIGNED 1-5-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-9-53	24c. NAME OF CEMETERY OR CREMATORY St. Peter's	24d. LOCATION (City, town, or county) (State) St. Louis Co. MO
DATE REC'D BY LOCAL REG. JAN 7 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter 2707 St. Louis	

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

Arthur L. Hellard

Licensed Embalmer No. *4221*

P. O. Address *4524 Aldine*

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.