

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8214**
Registrar's No. **598**

FILED MAR 4 - 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **546**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Overland		c. CITY OR TOWN Overland	d. Is Residence within limits of a city or incorporated town? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. LENGTH OF STAY (In this place) 7 yrs.		e. STREET ADDRESS (If rural, give location) 8217 Albin	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8217 Albin			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Henry c. (Last) Marion	4. DATE OF DEATH (Month) (Day) (Year) Feb. 19, 1953
---	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH May 17, 1863	9. AGE (In years last birthday) 89	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours Min.
--------------------	-------------------------------	---	--------------------------------------	---	-------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator	10b. KIND OF BUSINESS OR INDUSTRY Decorating	11. BIRTHPLACE (City and State or Foreign Country) Pike Co., Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	---	--	--

13a. FATHER'S NAME Baptiste Marion	13b. MOTHER'S MAIDEN NAME Savilla Scothorn	14. NAME OF HUSBAND OR WIFE Malinda
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ray Marion	ADDRESS 8217 Albin Ave.
--	-------------------------------------	---	--------------------------------

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration		Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____		Unknown
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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **2-15**, 19**53**, to **2-19**, 19**53**, that I last saw the deceased alive on **2-17**, 19**53**, and that death occurred at **12:00** m., from the causes and on the date stated above.

23a. SIGNATURE H. J. Feller M.D. (Degree or title)	23b. ADDRESS 2739 N. Grand	23c. DATE SIGNED 2-19-53
---	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-19-53	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Pleasant Hill, Ill.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 2-19-53	REGISTRAR'S SIGNATURE Herkert R. Danks-M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
---	--	---	--------------------------------------

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

No. 200
10-48

400X
1

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.....
Signature of Student Embalmer

Signed *JWm Bentley*.....
Licensed Embalmer No. *365*.....
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.