

No. 300
00.48

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28513**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1889**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY McLean	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay, Missouri		c. CITY OR TOWN Normal	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 3 yrs		e. STREET ADDRESS (If rural, give location) 2008 West Mulberry Street.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lemay Nursing Home			

3. NAME OF DECEASED (Type or Print)	a. (First) Bella	b. (Middle) Marsh	c. (Last) Augustine	4. DATE OF DEATH (Month) (Day) (Year) August 12, 1955
-------------------------------------	-------------------------	--------------------------	----------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 5, 1871	9. AGE (in years last birthday) 81	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Bloomington, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Benjamin P. Marsh, M.D.	13b. MOTHER'S MAIDEN NAME Fannie Ayres	14. NAME OF HUSBAND OR WIFE Archie Augustine, dec'd
---	---	--

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. Nil	17. INFORMANT'S SIGNATURE OR NAME Mrs. Areta Hamilton	ADDRESS 55 Loren Wood
--	------------------------------------	--	------------------------------

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 3 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic heart disease		
	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) _____		
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 4200	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) (m.)	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 **1/13**, 1955, to **8/12**, 1955, that I last saw the deceased alive on **8/12**, 1955, and that death occurred at **4:50 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Rebecca R. Romberg (Degree or title) M.D.	23b. ADDRESS 7615 So Broadway	23c. DATE SIGNED 8/13/55
--	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-13-55	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Normal, Illinois
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. 8/13/55	LOCAL REGISTRAR'S SIGNATURE Rebecca R. Romberg	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
---	---	---	--------------------------------

(Licensed Embalmer - Embalmment on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Paul A. Wachter*.....

Licensed Embalmer No. *478*.....

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.