

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38600

FILED DEC 12 1955

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1003

State File No. 10495  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>10495</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>				e. STREET ADDRESS (If rural, give location) <b>3146 Shenandoah</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>DAVID</b>		b. (Middle) <b>FRANKLIN</b>		c. (Last) <b>MARSHALL</b>		4. DATE OF DEATH (Month) <b>NOVEMBER</b> (Day) <b>28,</b> (Year) <b>1955</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>Feb. 10, 1880</b>	
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Marshall</b>		13b. MOTHER'S MAIDEN NAME <b>Adeline Lee</b>		14. NAME OF HUSBAND OR WIFE <b>Rosa Marshall</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Rev. C. W. Marshall, Pittsfield, Ill.</b> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>				DUE TO (b) <b>Arteriosclerotic Heart Disease</b>			<b>3 weeks</b>
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (c) _____			_____
II. OTHER SIGNIFICANT CONDITIONS				<b>Diabetes Mellitus</b>			_____
Conditions contributing to the death but not related to the disease or condition causing death.				_____			_____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		4200-4200		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? _____					
22. I hereby certify that I attended the deceased from <b>11-3</b> , 1955, to <b>11-28</b> , 1955, that I last saw the deceased alive on <b>11-28</b> , 1955, and that death occurred at <b>8:25pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Alan H. Beck M.D.</b> (Degree or title) _____				23b. ADDRESS <b>1515 LA FAYETTE AVE</b>		23c. DATE SIGNED <b>11-29-55.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11-29-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Wanda Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>South Roxana, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 30 1955</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington,</b>		_____	

(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

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.....  
*Edmond H. Reme*

Licensed Embalmer No. *421*

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.