

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38601**  
**9610**

FILED NOV 18 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

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 (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis</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 type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer Phillips Hospital</b>		STREET ADDRESS (If rural, give location) <b>6 5141 Palm St</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Lona</b>	b. (Middle)	c. (Last) <b>Marshall</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>11 2 55</b>
-------------------------------------	------------------------	-------------	---------------------------	--

5. SEX <b>F.</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>10-28-1882</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
------------------	-----------------------------	---	------------------------------------	---	------------------------	----------------------	----------------------	---------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Pickinscounty Ala.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
--	-----------------------------------	--	---

13a. FATHER'S NAME <b>Tom Nash</b>	13b. MOTHER'S MAIDEN NAME <b>Susia Strawbridge</b>	14. NAME OF HUSBAND OR WIFE <b>Tom 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>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Susia Jones</b>	ADDRESS <b>5141 Palm St</b>
--	-----------------------------------	--	-----------------------------

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 <b>Undt.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Generalized Arteriosclerosis</b> 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 <b>332X</b>	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 **10-26**, **1955**, to **11-2**, **1955**, that I last saw the deceased alive on **11-2**, **1955**, and that death occurred at **10:50am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Edw. B. Williams, M.D.</b>	23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>11-3-55</b>
--	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Miss</b>	24b. DATE <b>11-6-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Strew Bridge Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Ethelville Ala.</b>
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. <b>NOV. 4. 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Gus Howe</b>	ADDRESS <b>2930 Dickson St</b>
--	---	--	--------------------------------

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 *Leroy H. Fannia*.....

Licensed Embalmer No. *45*.....

P. O. Address *3880 E*.....

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. 11

If this body is not embalmed, fact should be so stated above.