

FILED DEC 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

43510

11385

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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, give TOWNSHIP only) OR TOWN ST. LOUIS MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.			Length of stay in 1 1/2 yrs.		d. STREET ADDRESS (If outside, give location) 3225 N. Florissant Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle MARRINER Last MARRINER				4. DATE OF DEATH Month DECEMBER Day 11 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5 1880	9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (City and state or country) Kent.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Marriner				14. MOTHER'S MAIDEN NAME Elizabeth Seawell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT The Sisters of the Poor 3225 Florissant			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripneural Vascular Collapse Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Heart Failure DUE TO (c) Arteriosclerotic Ht. Dis.						INTERVAL BETWEEN ONSET AND DEATH 420.0	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year. a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1/10/52 to 12/11/56 and last saw her/him alive on 12/11/56 . Death occurred at 8:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Charles E. Hogenson, M.D. (Degree or title)				22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 12/11/56.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Dec 13, 1956	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) St. Louis Mo		
24. FUNERAL DIRECTOR Arthur Donnelly 384 Linden			ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 11 1956	26. REGISTRAR'S SIGNATURE Carl Smith M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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 
Licensed Embalmer No. 46

P. O. Address 3810 L...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.