

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10255**
Registrar's No. **1859**

25754-57
FILED MAR 18 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 80th 18th			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital			d. STREET ADDRESS (If rural, give location) 17 2605 Arkansas			
3. NAME OF DECEASED (Type or Print) a. (First) Marion		b. (Middle) Michael	c. (Last) Forrest	4. DATE OF DEATH (Month) (Day) (Year) 2-21-57		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 2-21-57	9. AGE (In years last birthday)	10. UNDER 1 YEAR (Months) (Days)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS Mo		12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME Donald Forrest		13b. MOTHER'S MAIDEN NAME Ella Louise McFall		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Ella J Forrest		ADDRESS		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart - Intraventricular defect ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 15 min		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		754.2	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) 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 Feb. 21, 1957 , to Feb. 21, 1957 , that I last saw the deceased alive on Feb. 21, 1957 , and that death occurred at 9:15 P. m. , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) John V. Emmert M.D.		23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 2-22-57		
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 23 1957	24c. NAME OF CEMETERY OR CREMATORY ST. MATTHEW	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo			
DATE REC'D BY LOCAL REG. FEB-25 '57	REGISTRAR'S SIGNATURE St. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kuter 2906 Leavens				

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

Student Embalmer

Signed.....

James E. Hill

Licensed Embalmer No. 4347

P. O. Address 29 1/2 E. Travis

Not Embalmed

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