

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034496  
STATE FILE NUMBER  
8278  
Registrar's No.

FILED SEP 22 1958 Registration District No. 318 Primary Registration District No. 1003

300  
1-57

|  |                        |  |   |
|--|------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis   |                        | c. CITY OR TOWN St. Louis  |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 4563 Adkins Ave.  |                        | d. STREET ADDRESS (If outside, give location) 159 4563 Adkins Ave.   |   |
| 3. NAME OF DECEASED<br>(Type or print) First MARY Middle Last MARZOLFF   |                        | 4. DATE OF DEATH<br>Month Day Year Aug. 31 1958  |   |
| 5. SEX Female 1  | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 5, 1868  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework  |                        | 10b. KIND OF BUSINESS OR INDUSTRY At Home  | 11. BIRTHPLACE (City and state or country) Switzerland 5  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                        | 13a. FATHER'S NAME Aloys Dober   |   |
| 13b. MOTHER'S MAIDEN NAME Agatha Wiget   |                        | 14. NAME OF HUSBAND OR WIFE Late Charles Marzolff  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None   |                        | 16. SOCIAL SECURITY NO. None   |   |
| 17. INFORMANT Charles Marzolff Jr.   |                        | Address Lemay, Mo. 2752 Telegraph  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis / heart disease</u>   |                        |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <u>420.0</u>  |                        |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |                        |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour .Month, Day, Year<br>a.m.<br>p.m.  |                        |  |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>6/10/53</u> to <u>8/31/58</u> and last saw her alive on <u>8/31/58</u><br>Death occurred at <u>7:40 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                        |  |   |
| 22a. SIGNATURE <u>Walter J. [Signature]</u> (Degree or title)  |                        | 22b. ADDRESS <u>4617 Wablin Ave</u>  |   |
| 22c. DATE SIGNED <u>9/2/58</u>   |                        |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 23b. DATE Sep. 3, 1958   |   |
| 23c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.   |                        | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo.   |   |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway   |                        | 25. DATE RECD. BY LOCAL REG. SEP 2 58  |   |
| 26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u>   |                        |  |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

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 *Richard W. Storvick*

Licensed Embalmer No. *4007*

P. O. Address.....

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.