

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-027580

FILED VS AUG 7 1959

Registration District No. 317 Primary Registration District No. 547 STATE FILE NUMBER Registrar's No. 1989

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Msry's Hosp | | Length of stay in lb 2 Weeks | d. STREET ADDRESS (If outside, give location) 5511 Finkman Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle DICKSON Last MARSHALL | | | 4. DATE OF DEATH Month 7 Day 24 Year 1959 | | |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-7-1982 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Sy. Louis Mo | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME William D. Marshall | 13b. MOTHER'S MAIDEN NAME Mary McGee | 14. NAME OF HUSBAND OR WIFE Clara Marshall |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 490-05-0257 | 17. INFORMANT Clara Marshall Address 5511 Finkman Ave |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 204.1 |
| 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? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | 20d. INJURY OCCURRED WHILE AT <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 |
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| 21. I attended the deceased from <u>1954</u> to <u>7/24/59</u> and last saw her alive on <u>7/24/59</u> Death occurred at <u>5:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE <i>Edward Annella MD</i> (Degree or title) | 22b. ADDRESS 3720 Washington Ave | 22c. DATE SIGNED 7/26/59 |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-27-1959 | 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem | 23d. LOCATION (City, town, or county) (State) 4947 W. Florissant Av Mo |
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| 24. FUNERAL DIRECTOR <i>Piegenhite Bros</i> ADDRESS 6409 Gravois Av | 25. DATE RECD. BY LOCAL REG. 7-26-59 | 26. REGISTRAR'S SIGNATURE <i>J. B. Murphy M.D.</i> |
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
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.