

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 4 3 1

FILED VS DEC 21 1959 17

Registration District No. 517 Primary Registration District No. 500 Registrar's No. 3276

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moline		Length of stay in 1b 1 1/2 yrs.		c. CITY OR TOWN Moline		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Halls Ferry Memorial Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2115 Kappel Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle F. Last Marth				4. DATE OF DEATH Month December Day 4 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1875	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (City and state or country) Madison Co., Ill.		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Peter J. Marth			13b. MOTHER'S MAIDEN NAME Schoeneweis			14. NAME OF HUSBAND OR WIFE Unavailable		
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. None		17. INFORMANT Address Mrs. William Bosch, #1 Clayton Estates				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 _____ a.m. _____ p.m. Month _____ Day _____ Year _____								
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 Aug 1, 1959 to Dec 4, 1959 and last saw him alive on Nov 30, 1959 Death occurred at 6:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Louis Littmann MD (Degree or title)				22b. ADDRESS 8231 Clayton Rd (17)		22c. DATE SIGNED 12		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-7-59	23c. NAME OF CEMETERY OR CREMATORY Bunker Hill Cemetery		23d. LOCATION (City, town, or county) Bunker Hill, Mo.		(State)		
24. FUNERAL DIRECTOR Jacoby Funeral Home, Bunker Hill, Ill.			ADDRESS		25. DATE RECD. BY LOCAL REG. 12-8-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
NO EMBALM

Licensed Embalmer No. _____

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.

Franklin Hill Co.

Franklin Hill Cemetery

IS-1-2

Removed

Franklin Hill Cemetery, Franklin Hill, Ill.