URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-009231

FILED VS MAR 3 1960

ENDED

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 479 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY St. Louis.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland, Missouri. Length of stay in 1b YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8452 Lackland Road Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri. b. COUNTY ST LOUIS
c. CITY OR TOWN Overland Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 8452 Lackland, Road. Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Fearby Middle Isabelle Last Marsh
4. DATE OF DEATH Month February Day 12 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 1/16/1886
9. AGE (last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Hardin County, Ill.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William Hobbs
13b. MOTHER'S MAIDEN NAME Elizabeth Cullison
14. NAME OF HUSBAND OR WIFE Charles (DCSD)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.
16. SOCIAL SECURITY NO. None
17. INFORMANT F.L. Dodson, Address 8452 Lackland, Road Overland, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 3 Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan. 9 1960, to Feb 11 1960 and last saw her alive on Feb 11 1960
Death occurred at 1:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. R. M. Good D.O.
22b. ADDRESS 8367 Olive St. Rd
22c. DATE SIGNED 2-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-14-60
23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
23d. LOCATION (City, town, or county) (State) Flora, Illinois.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG. 2-12-60
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Robert M. Murra

Licensed Embalmer No. 3749

P. O. Address St Louis

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