

FILED VS AUG 17 1960

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. Grand, St. Louis, Mo.</b>		Length of stay in 1b <b>26 days</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>5075 GATES</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>EDWARD MARSHALL</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>2</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/93</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Shoe Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Mfg.</b>		11. BIRTHPLACE (City and state or country) <b>SCOTT CO., MO.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>JOSEPH H. MARSHALL</b>		13b. MOTHER'S MAIDEN NAME <b>MARY WATSON</b>	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>		16. NATIONAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Dora M. Calvin, 5075 Gates, St. Louis, Mo.</b>		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>DECOMPENSATED LAMNEC'S CIRRHOSIS</b>		
DUE TO (c) <b>581.1</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1) Congestive heart failure 2) Pelvic abscess</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.	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 <b>7/7/60</b> to <b>8/2/60</b> and last saw <b>him</b> alive on <b>8/2/60</b> Death occurred at <b>4:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank J. Carey M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>8/2/60</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairmont Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Cape Girardeau, Mo.</b>
24. FUNERAL DIRECTOR <b>Brinkoff-Howell, Cape Girardeau, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 3 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 8 1001

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Hauer  
Licensed Embalmer No. 4106  
P. O. Address St. Louis

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