

1. PLACE OF DEATH a. COUNTY <b>St. Louis Missouri</b>		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>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D. O. A Homer G. Phillip 4617 Easton Ave</b>		d. STREET ADDRESS (If outside, give location) <b>4649 Aldine Ave</b>	

3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>Marshall</b> Last			4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>16 Aug 97</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>2</b> Days	IF UNDER 24 HR Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	11. BIRTHPLACE (City and state or country) <b>Matteston Mississippi</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Rev A. G. Marchall</b>	13b. MOTHER'S MAIDEN NAME <b>O. C. Deloach</b>	13c. NAME OF HUSBAND OR WIFE <b>DEAD LEANA PROCTOR</b>
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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) <b>Yes One</b>	16. SOCIAL SECURITY NO. <b>493-24-9459</b>	17. INFORMANT Address <b>Mrs Leana Proctor 1925 Cora</b>
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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) <b>Coronary Occlusion (Sclerosis)</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>420.1</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <b>11:10</b> a.m. <b>PM</b> Month, Day, Year <b>11/8/60</b>	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.) <b>1110 Ave</b>	20f. CITY, TOWN, OR LOCATION <b>Jefferson Barrack</b> COUNTY <b>Jefferson Barracks</b> STATE <b>Mo</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Joseph M. Lusk Deputy Coroner</b> (Degree or title)	22b. ADDRESS <b>1200 Clark</b>	22c. DATE SIGNED <b>11-5-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/8/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Barrack</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo</b>
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24. FUNERAL DIRECTOR <b>Herman J. Smith</b> ADDRESS <b>4247/w Labadie</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 5 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith. M.D.</b>
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DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

Embalmer License No. \_\_\_\_\_

Name

Address

City, State and Zip

1. Name	2. Sex	3. Race	4. Age	5. Date of Birth	6. Date of Death	7. Cause of Death	8. Place of Death
9. Place of Burial	10. Name of Burial Place	11. Name of Embalmer	12. Signature of Embalmer	13. Date of Embalming	14. Signature of Student Embalmer	15. Date of Signature	16. Signature of Licensed Embalmer

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Thomas M. Robinson

Licensed Embalmer No. 4479

P. O. Address Cast St Row

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.