

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-046613**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12124**

STATE FILE NUMBER

AMENDED

DATE AMENDED

INS LEAD OF

BY AFFIDAVIT OF

**FILED JAN 11 1962**

|                                                                                                        |  |                                                                                                                        |                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                         |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |                                                                                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                  |  | Length of stay in lb<br><b>40 yrs.</b>                                                                                 | c. CITY OR TOWN <b>St. Louis</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>218 N. Sarah St.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS (If outside, give location)<br><b>218 N. Sarah Street</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                                                                              |  |  |                                                            |  |  |  |
|----------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>FLORENCE ELIZABETH MARKER</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 24, 1961</b> |  |  |  |
|----------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------|--|--|--|

|                         |                                  |                                                                                                                                                             |                                   |                                     |                                                          |                |
|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------|----------------------------------------------------------|----------------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/9/98</b> | 9. AGE (last birthday)<br><b>63</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>7 15</b> | IF UNDER 24 HR |
|-------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------|----------------------------------------------------------|----------------|

|                                                                                                                                       |                                                      |                                                                                    |                             |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Major Levy East St. Louis, Ill.</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mfg. Co.</b> | 11. BIRTHPLACE (City and state or country)<br><b>East St. Louis, Ill. U. S. A.</b> | 12. CITIZEN OF WHAT COUNTRY |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------|

|                                               |                                                             |                                                   |
|-----------------------------------------------|-------------------------------------------------------------|---------------------------------------------------|
| 13a. FATHER'S NAME<br><b>Edward Schilling</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret Clara Maschker</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Fred Marker</b> |
|-----------------------------------------------|-------------------------------------------------------------|---------------------------------------------------|

|                                                                                                                          |                                                                     |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 17. INFORMANT Address<br><b>Mrs. Irene Doak - E. St. Louis, Ill</b> |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|

|                                                                                                                                                                |                        |                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> |                        | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                                                     | DUE TO (b)             |                                  |
|                                                                                                                                                                | DUE TO (c) <b>4201</b> |                                  |

|                                                                                                                                   |                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                   |                                                                                                           |                                                                                              |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour a.m. p.m.<br>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 \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
Death occurred at **12:35.00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|                                        |                           |                                   |                                     |
|----------------------------------------|---------------------------|-----------------------------------|-------------------------------------|
| 22a. SIGNATURE<br><i>Paul J. Simon</i> | (Degree) <i>Physician</i> | 22b. ADDRESS<br><b>1300 Clark</b> | 22c. DATE SIGNED<br><b>12/26/61</b> |
|----------------------------------------|---------------------------|-----------------------------------|-------------------------------------|

|                                                            |                              |                                                                |                                                                              |
|------------------------------------------------------------|------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>12/27/61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Belleville, Illinois</b> |
|------------------------------------------------------------|------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------|

|                                                                    |         |                                                    |                                                     |
|--------------------------------------------------------------------|---------|----------------------------------------------------|-----------------------------------------------------|
| 24. FUNERAL DIRECTOR<br><b>John J. Kassly - E. St. Louis, Ill.</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 26 1961</b> | 26. REGISTRAR'S SIGNATURE<br><i>Paul Smith M.O.</i> |
|--------------------------------------------------------------------|---------|----------------------------------------------------|-----------------------------------------------------|

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 Not Embalmed, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed John J. Kasaly III

Licensed Embalmer No. 5039

P. O. Address E. 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.