

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41822

State File No. 10945
Registrar's No.

Registration District No. 791
Primary Registration District No. 1000

1. PLACE OF DEATH: 1
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 20
(If outside city or town limits, write "RURAL")
(d) Street No. 1519 ELLIOTT ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Helen Marshall 6214
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 21,
year 1939 hour 10:10 minute _____ A. M.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W
(b) Name of husband or wife John S. Marshall 6. (c) Age of husband or wife if alive _____ years
Birth date of deceased June 6 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 10, 1939 to December 21, 1939 and that I last saw her alive on December 21, 1939 and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months 5 Days 6 If less than one day _____ hr. _____ min.

Immediate cause of death Pneumonia, carcinoma of Cholelithiasis of Cholelithiasis
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy None

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____
12. Name John Kinsaid 5
18. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Quinn
15. Birthplace Quinn
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature J. P. Quinn
(b) Address 2504 Woodson Rd - Overland, Mo
17. (a) Burial (b) Date thereof 12-23-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cem.
18. (a) Signature of funeral director J. P. Quinn
(b) Address 2504 Woodson Rd - Overland, Mo
19. (a) DEC 22 1939 (b) J. P. Quinn
(Date of local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (Means of injury)
23. Signature J. P. Quinn (M. D. or other) 12/21/39
Address 1515 Lafayette, Date signed

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Oscar F. Mueller

Licensed Embalmer No. *3039*

P. O. Address. *Overland Mo.*

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 this body is not embalmed, above space should be left blank.