

S. No. 2
M-2.43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36674

State File No. _____

FILED DEC 3 1943
318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 10167

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community 2 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96
(c) City or town: Wellston, Mo. NR
(If outside city or town limits, write "RURAL")
(d) Street No. 6411 Mount Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Ralph Marsh

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 16 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Lawrence Marsh

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Viola Helmholt

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

16. (a) Informant Lawrence Marsh
(b) Address 6411 Mount Ave.

17. (a) Burial (b) Date thereof 11-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.

19. (a) NOV 2 (b) J. F. Buseck
(Date received back from office) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 18th.
year 1943 hour 8:00 AM minute _____ M.

21. I hereby certify that I attended the deceased from Nov 16 to Nov 18
that I last saw him alive on Nov 18 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Atrial Septal Defect

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 16

Major findings: Of operations _____

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 L. M. Birkdahl (M. D. or other)

Address 4500 Olive St. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

844

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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 Homer L. Ponder

Licensed Embalmer No. 5367

P. O. Address 2223 St. Louis ave

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, fact should be so stated above.