

V. S. No. 2  
FORM—8-43  
REV. 5-17-39  
I X37823

32002

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8169**

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

100  
17  
9

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
BETHESDA GENERAL HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 days  
(Specify whether \_\_\_\_\_)

In this community 40 yrs  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 96

(c) City or town KIRKWOOD  
(If outside city or town limits, write "RURAL") NR 3

(d) Street No. 1001 Big Bend Road  
(If rural, give location)

(e) Citizen of foreign country? no (yes or No) /

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME marsh, Susan Mrs.

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22  
year 46 hour 10 minute 35 P.M.

21. I hereby certify that I attended the deceased from August 2 31st, 1946, to Sept 21st, 1946  
that I last saw her alive on SEPT 21, 1946  
and that death occurred on the date and hour stated above.

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife EDGENE MARSH

6. (c) Age of husband or wife if alive 33 years (Day) (Year)

7. Birth date of deceased April 23 67  
(Month) (Day) (Year)

Immediate cause of death Cardiac Decompenation

Due to Arteriosclerotic Heart Disease

Due to \_\_\_\_\_

Other conditions 92  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

79 4 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Froy Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name CLYDE MING GOTTON

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

14. Maiden name ANNA CONNOR ROLLIN

15. Birthplace TIPOYS INDIANA  
(City, town, or county) (State or foreign country)

16. (a) Informant WILBER MARSH

(b) Address 225 W. JEWEL AVE. KIRKWOOD

17. (a) BURIAL (b) Date thereof SEP 24 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BELLEFONTAINE CEM.

18. (a) Signature of funeral director Parther and Co

(b) Address WEAVER GROVES MO

19. (c) SEP 23 1946 (Date received local registrar)

J. F. Bredeck (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) (e) Means of injury /

23. Signature George S. Mohr (M. D. or other) MD

Address Bethesda General Hosp. Date signed 9-22-46

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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 *W. A. Aldrich*

Licensed Embalmer No. 1332

P. O. Address *Webster Groves 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, fact should be so stated above.**