

26397

FILED JUL 30 1947

Registration District No.

Primary Registration District No.

6076

Registrar's No.

1572

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town St. Louis Koch
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 171 days (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 40 53 Olive St.
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Marion Francis Sawyer

3. (b) If veteran, name war No 3. (c) Social Security No. 490-01-8892

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife FLORE SAWYER
6. (c) Age of husband or wife if alive UNK.
7. Birth date of deceased DECEMBER 6 1885

8. AGE: Years 61 Months 7 Days 14 If less than one day hr. min.

9. Birthplace Litchfield (City, town or county) Ill. (State or foreign country)

10. Usual occupation Clerk
11. Industry or business Hotel

MOTHER FATHER

12. Name Marion Sawyer
13. Birthplace Ill.
14. Maiden name Rachel Raymond
15. Birthplace Kentucky

16. (a) Informant Koch Hosp. Records
(b) Address _____

17. (a) BURIAL (b) Date thereof 7-23-47
(c) Place: burial or cremation MEMORIAL PARK CEMETERY

18. (a) Signature of funeral director Robert W. Haggard
(b) Address 4700 Washington Blvd.
(c) Date received from Registrar 7-24-47

19. (a) 7-24-47 (b) Robert W. Haggard
(Date received from Registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20 year 1947 hour 4 minute 55 A.
21. I hereby certify that I attended the deceased from 1-31- to 7-20-47
that I last saw him alive on 7-19 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 1 1/2 yrs.

Due to _____
Due to 136

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(c) Means of injury _____
23. Signature William A. Nelson (M. D. or other) MD
Robert Koch Hosp. Date signed 7-20-47

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

96
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OCT 2 1961

JUL 30 1961

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 *J. Allen Davis*
.....
Licensed Embalmer No. *4053*
.....

P. O. Address.....

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.