

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

17247  
Do not use this space.

RECD JUN 12 1939

**1. PLACE OF DEATH**

(a) County ..... 1 Registration District No. .... 791  
 (b) Township ..... Primary Registration District No. .... 1008  
 (c) City ..... St. Louis / (d) Street No. .... City Hospital No. 1 ..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME**

Charles Dorsey  
 (a) Residence, No. .... 218 South 4th St. [25] ..... (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ..... male  
 4. COLOR OR RACE ..... white  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) ..... single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ..... April 8, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
 69 1 10

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. .... nil  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ..... Illinois 1

FATHER  
 13. NAME ..... Tim Dorsey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ..... Ireland 5

MOTHER  
 15. MAIDEN NAME ..... Catherine Scullin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ..... Ireland

17. INFORMANT (ADDRESS) ..... Hosp. Infb M. Kent

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE ..... CEMETARY DATE ..... 5-26-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) ..... Cullen + Kelly  
 1416 N. Taylor Ave.

20. FIVE DAY PERIOD ..... MAY 26 1939  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... 5/18/39 19

22. I HEREBY CERTIFY, That I attended deceased from 5/16/39 19, to 5/18/39 19.

I last saw him alive on 5/18/39 19. Death is said to have occurred on the date stated above, at 5.30 p.

The principal cause of death and related causes of importance were as follows:

Carcinoma of face + neck  
 Primary seat skin of left cheek

Date of onset

Other contributory causes of importance: 52

Name of operation ..... Date of

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....  
 (Signed) William Hapsin, M. D.  
 (Address) City Hospital No. 1

I X18625

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.

WHILE EXAMINING WITH EMPLOYING AGENCY—THIS IS A PERMANENT RECORD

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.....

*Raymond E. Gerke*

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

working under my personal supervision.

Signed.....

*Raymond E. Gerke*

Licensed Embalmer No.....

*3985*

P. O. Address.....

*St Louis, Mo*

*City license #99*

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.