

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

Rev. 5-17-39
1 X10511

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34779

791
7000
Registration District No. 7000

Primary Registration District No.

State File No.

Registrar's No. 9317

1. PLACE OF DEATH:
 (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 9 Days
 (Specify whether _____)
 In this community Life
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 23
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2717 St. Vincent
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Charles Doran 650
 3. (b) If veteran, name war. -----
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Sophie
 6. (c) Age of husband or wife if alive --- years
 7. Birth date of deceased January 4 1871
 (Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 26
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Doctor

11. Industry or business _____
 MOTHER FATHER { 12. Name Patrick Doran
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Ireland
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edward Kormicker
 (b) Address 4600a Delmar

17. (a) Burial (b) Date thereof 11/1/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wacker-Welderle
 (b) Address 2331 S. Broadway

19. (a) Oct 31 1939 (b) J. F. Budek
 (Date of registration) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 30,
 year 1939 hour 4:45 minute A. M.
 21. I hereby certify that I attended the deceased from October
22, 1939, to October 30, 1939

that I last saw him alive on October 30, 1939
 and that death occurred on the date and hour stated above.
 Immediate cause of death Myocarditis
Chronic

Due to Emphysema Pulmonary
 Due to Generalized arteriosclerosis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy As above
 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)
 (e) Means of injury _____
 23. Signature J. J. Laro (M. D. or other) _____
 Address 1518 Lafayette 10/20/39

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.....

Frank J. Myland Sr.

Licensed Embalmer No. *2675*

P. O. Address *St Louis 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.