

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24218

State File No. 2858

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Hour & 26 Min.
In this community 2 Years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Mr. William H Doerges

3. (b) If veteran, name war No 8. (c) Social Security No. 159-05-3672

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

6. (b) Name of husband or wife Ellen McMahon Doerges 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased March 9 1887
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Superintendent

11. Industry or business Chase Bag Co.

12. Name William H. Doerges

18. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Rhoda May

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John H Hagedorn
(b) Address Detroit Michigan

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 19, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D. W. Newcomer Sr
(b) Address 1401 Brush Creek Blvd.

19. (a) July 17, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(b) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3317 College
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16 year 40 hour 4:56 minute 17 M.

21. I hereby certify that Crowe attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of the skull

Due to Fall down elevator shaft.

Due to 2037

Other conditions 12
(Include pregnancy within 5 months of death)

Major findings: Of operations _____

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 7/16/40

(c) Where did injury occur? 116 W 3rd Kansas
(City or town) (County) (State)

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

While at work? Yes (Specify type of place) (e) Means of injury Fall

23. Signature M. M. Crowe (M. D. or other) 7/16/40
Address Crowe Date signed

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

MOTHER FATHER

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 *A. C. Newcomer Jr.*

Licensed Embalmer No. 4043

P. O. Address *S. C. 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.