

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33675**
Registrar's No. **8373**

NOV 16 1940

791

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME **Anna Wuhrman Dockery**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Late Frank Dockery** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 14th 1867**
(Month) (Day) (Year)

8. AGE: Years **73** Months **2** Days **23** If less than one day
hr. min.

9. Birthplace **Cincinnati** **Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **James White**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Lenora Mulroy** (State or foreign country)

15. Birthplace **Michigan**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Miller**

(b) Address **4708 Vienna Ave.**

17. (a) **Burial** (b) Date thereof **10-10-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Kriegshauser Mortuaries**

(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **OCT 8 1940** (b) **J. B. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **145**
(If outside city or town limits, write "RURAL")
(d) Street No. **4708 Vienna**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **7th**
year **1940** hour **2:25** minute **P.M.** M.

21. I hereby certify that I attended the deceased from **10-5-40**
_____ 19____, to **10-7-40** 19____;
that I last saw her alive on **10-7-40** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to **Chronic Myocarditis**

Due to **Senility**

Other conditions **No**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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 **Pugh Haines Jr** (M. D. or other) _____

Address **4960 Pacific** Date signed **10/8/40**

Mr J. J. W. W. W.
4949 Buckinghorse Ct,
No 3562 Thine

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

Edmund M. Dermott

Licensed Embalmer No.

3024

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.