

FILED FEB 1 1943
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Registration District No.

Primary Registration District No. 1003

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:
Res:- 6240 Rosebury Ave.,
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. #6240 Rosebury Ave.,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Lt. Col. Arthur H. Doig.

3. (b) If veteran, name war World War I. 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Adelaide Doig. 6. (c) Age of husband or wife if alive 50. years

7. Birth date of deceased December, 11 1884.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58. 1. 6. hr. min.

9. Birthplace Ellsworth, Kansas.
(City, town, or county) (State or foreign country)

10. Usual occupation Lieut. Colonel of U. S.

11. Industry or business Army, Retired.

12. Name Robert L. Doig.

13. Birthplace Washington, Iowa.
(City, town, or county) (State or foreign country)

14. Maiden name Adda Jacks.

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

16. (a) Informant Mrs Adelaide Doig.

(b) Address #6240 Rosebury Ave.,

17. (a) Removal. (b) Date thereof 1-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arlington Cemetery

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address #7233 Delmar Boulevard,

19. (a) 1943 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan'y day 17th
year 1943. hour 6:30 minute 2 P.M.

21. I hereby certify that I attended the deceased from Several years
19..... to Jan 17, 1943

that I last saw him alive on Jan 16, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Branch pneumonia Duration 4 days

Due to.....

Due to.....

Other conditions Parkinson's disease several years
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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)

Means of injury.....

23. Signature Oliver Luten D (M. D. or other)

Address Washington, Mo Date signed 1-18-43

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

MOTHER FATHER

MAR 22 1949

Dr. Drew Luten.
3720 Washington.
JE: 2866.
375 P.M.

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 Clarence H. Murray
Licensed Embalmer No. 4011
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, fact should be so stated above.

Amended Report
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:.....
(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 *Arthur Haldane Daig*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

{ 14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) { Burial, cremation, or removal } (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) { Date received local registrar } (b) { Registrar's signature }

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION *Amended*

20. DATE OF DEATH: Month *January* day *17*
year *1943* hour *6* minute *30 A.M.*

21. I hereby certify that I attended the deceased from *for several*
years to *Jan 17*, 19*43*
that I last saw him alive on *Jan 16*, 19*43*
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Parotiditis
Due to *Bronchopneumonia*
Due to *Contributory*

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration
many
days

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)
(g) Means of injury.....

23. Signature..... (M. D. or other).....

Address *St Louis Mo* Date signed *3-5-43*

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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.....

Licensed Embalmer No.....

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.