

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12066  
12066  
State File No. \_\_\_\_\_  
Registrar's No. 3852

FILED MAY 3 1943 318  
Registration District No. \_\_\_\_\_

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 MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST JOHNS HOSP O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 HOURS  
(Specify whether  
In this community 11 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 318  
(c) City or town MAPLEWOOD MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2503 BREDELL AVE  
(If rural, give location) 1  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME GRACE EDA DOYER

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife MILBOURNE E DOYER 6. (c) Age of husband or wife if alive 34 years  
7. Birth date of deceased JULY 5 1916  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
26 9 17 20 hr. 30 min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name ARTHUR S DARNER  
13. Birthplace TAYLORVILLE ILL  
(City, town, or county) (State or foreign country)  
14. Maiden name MAMIE MOORE  
15. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

16. (a) Informant M E Doyne  
(b) Address 2503 BREDELL AVE

17. (a) BURIAL (b) Date thereof 4/27/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CANARY CEMETERY

18. (a) Signature of funeral director Walter Doyne  
(b) Address 6136 Clayton Rd

19. (a) APR 28 1943 (b) J. F. Bredeat  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 23  
year 1943 hour 8 minute 50 P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Asphyxiation by inhalation of large amount of Venetian Turpentine  
of Grade Unsatisfactory, during child birth  
at St. John's Hospital, Assen. 23  
1943 about 8:50 O'clock PM  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1935

Major findings: GA  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? NO

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury \_\_\_\_\_

23. Signature J. F. Bredeat (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 4/26/43

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.....

*J. Allen Davis Jr*

Licensed Embalmer No.....

*4053*

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.**