

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8699

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Park Lane Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Diane Dohr

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

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

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

7. Birth date of deceased September 21<sup>th</sup> 1913  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>6</u>	.....hr. ....min.

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

10. Usual occupation None

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

12. Name Albert Dohr

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

14. Maiden name Mabel Dugan

15. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Dohr

(b) Address 2326 Burns Ave Overland

17. (a) Burial (b) Date thereof. 10/1/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Churchyard

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 8663 Clayton Mo.

19. (a) \_\_\_\_\_ 1949 J. F. Bredest  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town Overland  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2326 Burns Ave  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 30<sup>th</sup>,  
 year 1943 hour 2.30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Sept 18, 1943 to Sept 24, 1943

that I last saw her alive on Sept 24, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Sclerosis Neonatorum

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: None  
 Of operations \_\_\_\_\_

Of autopsy None

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)  
 (b) Means of injury \_\_\_\_\_

23. Signature John Brisson (M. D. or other) \_\_\_\_\_

Address 2648 Oakview Ave Date signed 9/30/43

NR

161

Duration

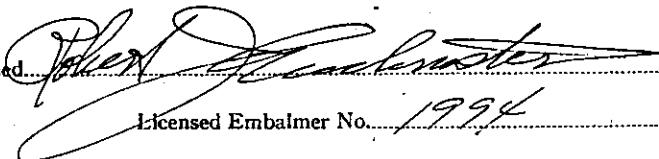
PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

..... Not Embalmed ....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  .....

Licensed Embalmer No. 1994 .....

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.**