

318

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
8583 Riverview Blvd.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community Life \_\_\_\_\_ (Specify whether  
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. 8583 Riverview Blvd.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Adelaide B. Doell

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7th,  
year 1944 hour 7:50 minute A. M.

21. I hereby certify that I attended the deceased from  
June 29, 1943, to Jan 7, 1944  
that I last saw her alive on Jan 6-44, 1944;  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Walter R. Doell

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March 19, 1890  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Carcinoma of recto-sigmoid  
Sigmoid with general li  
Due to metastases

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

|    |   |    |          |
|----|---|----|----------|
| 53 | 9 | 19 | hr. min. |
|----|---|----|----------|

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

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

Major findings:  
Of operations no

Of autopsy no

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

10. Usual occupation Housework

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name George Westermann

13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ema Lochmoller

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

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? \_\_\_\_\_

16. (a) Informant Mr. Walter R. Doell

(b) Address 8583 Riverview Blvd.

17. (a) Burial (b) Date thereof Jan. 10, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director CALVIN F. FEUTZ FUNERAL HOME

(b) Address 4828 Natural Bridge Blvd.

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

23. Signature George J. Bradley (M. D. or other) MD

Address 624 7th Street Date signed 1-8-44

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

NOV 20 1944

Mr. Skuter Body  
2:45 to 3:30 PM

**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 John Mlinar

Licensed Embalmer No. 41-86

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.**