

FILED SEP 30 1944

1003

Registration District No. 318

Primary Registration District No.

Registrar's No. 7987

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:
2540a W Sullivan Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 57 Yrs. 0 Mon. 2 Days
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town St. Louis Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2540a W Sullivan Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Fred Doelling

3. (b) If veteran, name war no 3. (c) Social Security No. 494-07-7148

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

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

7. Birth date of deceased 9 14 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 0 2 hr. min.

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

10. Usual occupation Clerk

11. Industry or business

12. Name August Doelling

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

14. Maiden name Mitheldo Giessler

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

16. (a) Informant Mrs. Beulah Doelling

(b) Address 2540a W, Sullivan Ave

17. (a) Burial (b) Date thereof 9-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address 2228 St. Louis Ave

19. (a) SEP 18 1944 (b) J. J. Deneed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 16
year 1944 hour 4 minute 30 a. m.

21. I hereby certify that I attended the deceased from August 25, 1944 to 9-16-1944
that I last saw him alive on 9-15-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to Chronic Myocarditis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 Cliff Simons (M. D. or other) M.D.

Address 2202 University Date signed 9/16/44

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

MOTHER FATHER

Duration

1 day

1 yr.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Maple A. Cashion*

Licensed Embalmer No. *3949*

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.