

FILED JAN 4 3 1945

Registration District No. _____

Primary Registration District No. **6048**

1. PLACE OF DEATH:

(a) County... **St. Charles**

(b) City or town... **Dardennes**

(c) Name of hospital or institution... **Rural Dardennes Sup**
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution... **3 months** | (Specify whether years, months or days)

In this community... _____

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Mo** (b) County... **St. Charles**

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

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

(e) Citizen of foreign country? **No** | (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME... **LILLIAN B. DORAIS**

3. (b) If veteran, name war _____

3. (c) Social Security No. **497-03-1270**

4. Sex... **Female**

5. Color or race... **White**

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

6. (b) Name of husband or wife... _____

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

7. Birth date of deceased... **October 15 1904**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
40	1	28	hr. _____ min. _____

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

10. Usual occupation... **Beauty operator**

MOTHER FATHER

11. Industry or business... **" "**

12. Name... **Leo Dorais**

13. Birthplace... **O'Fallon Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name... **O'Fallon**

15. Birthplace... **O'Fallon Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant... **Anna Dorais**

(b) Address... **O'Fallon, Mo.**

17. (a) (Burial, cremation, or removal)... **Burial**

(b) Date thereof... **Dec 11 1944**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director... **W. J. Peterson**

(b) Address... **Westville Mo**

19. (a) **Dec 22 1944** | **E. A. Kethley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month... **Dec**, day... **8**
year... **1944**, hour... **12:05**, minute... **17**, M.

21. I hereby certify that I attended the deceased from **Nov 1**
19 **44** to **Dec 6** 19 **44**
that I last saw her alive on **12/6** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death... **Carcinoma of urinary bladder**

Due to... _____

Due to... **524**

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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... **H. C. Mc Murray** | **W. D.**
Address... **Westville, Mo** | Date signed **12/9/44**

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

FEB 20 1945

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-3-45

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 T. E. Romano

Licensed Embalmer No. 2711

P. O. Address W. Fitzgerald, M.

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.