

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7096

State File No. _____

417

Registrar's No. _____

FILED FEB 24 1945
Registration District No. 377

Primary Registration District No. 6076

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

no
17
9

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4655 Oldenburg
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 77 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Emma Doering

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 Married
6. (b) Name of husband or wife August Doering, Sr. 6. (c) Age of husband or wife if alive --79 years
7. Birth date of deceased St. Louis, Missouri
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 2 24 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Henry Wolters

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

14. Maiden name Sachleben

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

16. (a) Informant Mr. August Doering, Sr.

(b) Address 4655 Oldenburg

17. (a) Burial (b) Date thereof Feb. 9, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Beiderwieden F. H., Inc.

(b) 1936 St. Louis Avenue

19. (a) FEB 11 1945 (b) E. G. M. Gorman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County (St. L. Co.)
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4655 Oldenburg
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9,
year 1945 hour 2: minute 45 A.M.

21. I hereby certify that I attended the deceased from
Jan 15, 1931, to Feb 9, 1945
that I last saw her alive on Feb 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Arterio Sclerosis
Chronic myocarditis
Due to _____

Due to Cardiac Failure
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations: _____
Of autopsy: 9/30

Duration

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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Adam S. Youngman (M. D. or other) M.D.
Address 5439 42nd Ave Date signed 2/9/45

Dr. Adam Youngman
5439 Kansas

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.....

Glen W. Katz

Licensed Embalmer No. *3737*

P. O. Address. *936 N. Louisa*

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.