

FILED JUN 19 1945

Registration District No. 317

Primary Registration District No. 3062

State File No. 21196

Registrar's No. 1175

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Brentwood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2825 Lawndell
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 53 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Catherine Doellefeld

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, Widowed

6. (b) Name of husband or wife Dr. Adam H. Doellefeld 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 14, 1892
(Month) (Day) (Year)

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

53 4 6 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 Julius Stupp

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

{ 14. Maiden name Ida Bieger

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

16. (a) Informant Mrs. Victor Mandeville

(b) Address 2825 Lawndell

17. (a) Burial (b) Date thereof 5-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 1936 St. Louis Avenue

19. (a) MAY 22 1945 (b) E. G. McCarroll, M.D.
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 313 South Illinois
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20,
year 1945 hour 8; minute 00 P. M.

21. I hereby certify that I attended the deceased from Dec. 22, 1944, to May 20, 1945,
that I last saw her alive on May 20, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of colon with generali-
zed Metastasi of the liver, etc. Duration 6 mo.

Due to 46e

Due to _____

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

23. Signature S. H. [Signature] (M. D. or other) 0

Address 3066 [Signature] Date signed [Signature]

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.....

Delix J. Krupin

Licensed Embalmer No.....

3497

P. O. Address.....

1936 St. Louis

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:

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