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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25578

State File No.

FILED AUG 24 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6912

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

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS MO (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 11 days In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")

(d) Street No. 5443 SUNSHINE DR (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME GIDEON DOREY

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife ANNA

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased — (Month) (Day) (Year)

8. AGE: Years abt 88 | Months — | Days — | If less than one day hr. min.

9. Birthplace ST. JOSEPH MO (City, town, or county) (State or foreign country)

10. Usual occupation BOOKBINDER

11. Industry or business RETIRED

FATHER 12. Name FREDERICK DOREY

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

MOTHER 14. Maiden name UNKNOWN

15. Birthplace FRANCE (City, town, or county) (State or foreign country)

16. (a) Informant ANNA DOREY

(b) Address 5443 SUNSHINE DR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 8 45 (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 SO KINGSHIGHWAY

19. (a) AUG 6 1945 (Date rec'd by local registrar) J. J. Bradley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5 year 1945 hour 6 PM minute 10 M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia | Duration

Fracture of pelvis received when he fell from a examining table at the Washington University Clinic at 1.30 P.M. July 25 1945

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) Accident

(b) Date of occurrence July 25 1945

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Washington U. Clinic (Specify type of place)

While at work? (e) Means of injury as above

23. Signature Patrick E. Taylor (M. D. or other)

Address Aly Kor Date signed 8/6/45

(Licensed Embalmer's Statement on Reverse Side)

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 Elwin D. McDermott

Licensed Embalmer No. 3024

P. O. Address.....

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.