

7. S. No. 2  
DOM-5-43  
ev. 5-17-39  
I X36671

**FILED** DEC 12 1945  
Registration District No. DEC 12 1945

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 10577

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
4846a St. Louis Ave. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 47 years (Specify whether years, months or days)

In this community 47 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 4846a St. Louis Ave.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Eva Doerflinger

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female

5. Color or race White

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

6. (b) Name of husband or wife late Charles C. Doerflinger

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

7. Birth date of deceased Dec 29th, 1881  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4th.  
year 1945 hour 4:00 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 38, to 12/3, 1945  
that I last saw h.e. alive on 12/3, 1945.  
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 11 Days 5  
If less than one day hr. min.

Immediate cause of death Chronic myocarditis Duration 10 yrs.

Due to Valvular disease 3:

Due to Arteriosclerosis of liver 2 years.

Other conditions (Exclude pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

Major findings: Of operations none

Of autopsy none

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mr. Thomas Doerflinger

(b) Address 4411 June Ave.

17. (a) Burial Memorial Park Cemetery  
(Burial, cremation, or removal) (b) Date thereof 12-7-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) DEC 5 1945 (b) J. F. Bredsch  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. J. Pappas (M. D. or other) MD

Address 529 8a Page Date signed \_\_\_\_\_

1881-64

W. C. W. ...

**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..... *John P. Buchholz* .....

Licensed Embalmer No. *1674* .....

P. O. Address. *2223 St. Louis Ave* .....

**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.**