

**FILED** DEC 12 1945

Registration District No. 310 Primary Registration District No. 3058

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

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution:  
2300 North Benton  
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Douglas Edward Regot

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex male 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 3, 1945  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>1</u>	<u>22</u>	hr. min.

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

10. Usual occupation None

11. Industry or business Child

12. Name Alva Regot

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

14. Maiden name Katherine Arans

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

16. (a) Informant Alva Regot (father)

(b) Address 2300 N. Benton-St. Charles, Mo.

17. (a) burial (b) Date thereof 11-26-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove-St. Charles, Mo.

18. (a) Signature of funeral director. H. C. Wallmeyer & Son Co.

(b) Address 800 N. 2nd -St. Charles, Mo.

19. (a) 11-26-1945 (b) Ernest G. Paul  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 2300 North Benton  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25  
year 1945 hour 10:30 minute..... P.M.

21. I hereby certify that I attended the deceased from NOV-25-45  
..... 19....., to NOV-25-45 19.....  
that I last saw h. Im alive on NOV-25-45 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia Duration.....

Due to Congenital Debility

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).....

(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 Dr. F. L. Arrington M.D. or other D.O.  
Address St. Charles Mo Date signed 11-26-45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-11-45

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**