

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42324**
Registrar's No. **10832**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 23 1946 **318**

Registration District No. _____ Primary Registration District No. **1003**

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:
St. Louis City Hospital - Max C. Starkloff
(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 FRANCIS DORRIS
3. (b) If veteran, name war No **3. (c) Social Security No.** None
4. Sex Female **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 April 29, 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 7 18 _____ hr. _____ min.

9. Birthplace: St. Louis, Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation None

11. Industry or business _____
12. Name John Dorris
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Mary L. Monunts
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant John Dorris
(b) Address Florissant, Mo.
17. (a) Burial Dec. 18/46
(Burial, cremation, or removal) **(b) Date thereof** Dec. 18/46
(c) Place: burial or cremation Sacred Heart Cem., Florissant, Mo.
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,
19. (a) DEC 18 1946 J. F. Bredenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Florissant
(If outside city or town limits, write "RURAL")
(d) Street No. 1290 St. Catherine St.,
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 17th
year 1946 hour 5:18 minute A M.
21. I hereby certify that I attended the deceased from 12/13/46
_____, 19____ to Dec. 17th, 1946
that I last saw h.er alive on Dec. 17th, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hyperpyrexia Duration _____
Bronchitis
Due to _____
Due to _____
Other conditions Chondroptrophy
(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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature 1515 Lafayette 12/19/46 (other) _____
Address _____ Date signed _____

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

Alfred J. Bredke

Licensed Embalmer No. 2663

P. O. Address. 1125 Hodiamont 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.