

FILED DEC 23 1946

318

Primary Registration District No.

1003

Registrar's No.

10810

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town ST LOUIS  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
CITY HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community.....  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County.....  
 (c) City or town ST LOUIS  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2616 PARK AV.  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No) 0  
 If yes, name country.....

3. (a) PRINT FULL NAME LEO E. DOUGHERTY

3. (b) If veteran, name war WAR II 3. (c) Social Security No. 495-12-6224

4. Sex MD 5. Color or race White 6. (a) ~~Single, widowed, married,~~ divorced MAR.

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

7. Birth date of deceased APR 27 1910  
 (Month) (Day) (Year)

8. AGE: Years 36 Months 7 Days 19 If less than one day hr. min.

9. Birthplace ST LOUIS Mo D  
 (City, town, or county) (State or foreign country)

10. Usual occupation PLUMBER

11. Industry or business.....

MOTHER FATHER { 12. Name WALTER J. DOUGHERTY

13. Birthplace ST LOUIS Mo D  
 (City, town, or county) (State or foreign country)

14. Maiden name STELLA TICE

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

16. (a) Informant STELLA DOUGHERTY

(b) Address 2616 PARK AVE

17. (a) BURIAL (b) Date thereof 12/19/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schnur

(b) Address 3125 Lafayette Ave

19. (a) DEC 17 1946 (Date received local registrar) J. F. Biedrich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16 year 1946 hour 9 minute 15 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 Internal & External Pyrexia

from gun shot wound of  
Woodbury self-inflicted  
at his home at 11/16/46  
about 5:40 PM in garage while  
repairing from temporary mental  
alteration

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

Major findings: Of operations H&T

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) suicide

(b) Date of occurrence Dec 16 1946

(c) Where did injury occur? at home  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home

While at work? at home (Specify type of place) (e) Means of injury 2 shot

23. Signature J. F. Biedrich (M. D. or other)

Address 3125 Lafayette Ave Date signed.....

MAR 31 1948

**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.....

*Jose B. Vollmer* BI  
Licensed Embalmer No. *4014*  
P. O. Address *St Louis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

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(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(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 Leo E. Daugherty  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Apr 27  
Month Day Year

8. AGE: Years 36 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Dec-17-1946 (b) J. F. Bredekamp  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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) \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE IN FAINTLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

42327

0866-77