

S. No. 2
M-1/47
v. 5-17-39

National Office of Vital Statistics
FILED NOV 28 1947 318

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 10397

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: 6731 Fyler /
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6731 Fyler Avenue
(If rural, give location)
(e) Citizen of foreign country?..... No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9th
year 1947 hour 3 minute 05 A. M.

21. I hereby certify that I attended the deceased from.....
Oct 14 1947 to Nov 9 1947
that I last saw her alive on..... 1947
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death.....
Chronic Myocarditis
Due to.....
Heart insufficiency
Due to.....
Other conditions.....
Chronic Interstitial Neph.
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause of 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?..... (Specify type of place)
While at work?..... (e) Means of injury.....
23. Signature Kate F. Henke (M. D. or other)
Address 3109 So. Grand Blvd Date signed 11/11/47

3. (a) PRINT Dr. Libby R. Doll
FULL NAME

3. (b) If veteran, name war.....
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph E.
6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased December 21st, 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>10</u>	<u>18</u> hr. min.

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

10. Usual occupation Medical Doctor

11. Industry or business.....

12. Name Charles W. Libby

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

14. Maiden name..... Unknown

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

16. (a) Informant Dr. Joseph E. Doll

(b) Address 6731 Fyler, St. Louis, Mo.

17. (a) Burial (b) Date thereof 11/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Wacker-Keller & Co.

(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) NOV 12 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 _____

Frank J. O'Hara

Licensed Embalmer No. _____

21645

P. O. Address _____

Arkham

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.