

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

18269

National Office of Vital Statistics

FILED APR 30 1948

State File No. _____

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 9819

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Missouri Lemay
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 10
4840 Heidelberg Avenue
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ 68 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County ool
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 4840 Heidelberg Avenue 9
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME August Doering, Sr.
 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 Emma Wolters 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased August 31, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	7	16	_____ hr. _____ min.

9. Birthplace Pomerania, Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Janitor

11. Industry or business Salem Lutheran Church

12. Name Karl Doering 4

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Doering

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Miller

(b) Address 4840 Heidelberg Avenue

17. (a) Burial (b) Date thereof 1/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director BEIDERWIEDEN F.H., INC.

(b) Address 1936 St. Louis Avenue

19. (a) 4-17-48 (b) George H. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
 year 1948 hour 9: minute 15 A. M.

21. I hereby certify that I attended the deceased from 17 Nov, 1947, to 16 April, 1948,
 that I last saw him alive on 15 April, 1948,
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 48 hrs
Duration

Due to Arterio sclerosis Generalized ?

Due to 83a

Other conditions _____
(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 George H. ... (M. D. or other) MD

Address 5437 GRAND AVE Date signed 16 April

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

MOTHER FATHER

Dr. Geo. A. Youngman
5439 Gravois Avenue

1-3 6-8

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.....

Max L. Waibel

Licensed Embalmer No. *4170*

P. O. Address *1936 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.

2B
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43889

State File No. June
Registrar's No. 989

Registration District No. 317

Primary Registration District No. 2

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Deming
(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

August Doerning

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 _____ years

7. Birth date of deceased Aug 3
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

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) _____ (b) _____
(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 _____ Day _____ Year 1944 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 _____

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

SUPPLEMENTARY

