

FILED FEB 23 1949

STANDARD CERTIFICATE OF DEATH

State File No. **6113**
1039
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY-REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.	
c. LENGTH OF STAY (in this place) 79yrs		d. STREET ADDRESS (If rural, give location) 4176 Delmar Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4176 Delmar			

3. NAME OF DECEASED (Type or Print) Elizabeth Dooling			4. DATE OF DEATH (Month) (Day) (Year) Feb. 2 1949		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 6 1873		9. AGE (In years) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME John Lynch		13b. MOTHER'S MAIDEN NAME Elizabeth Fagan		14. NAME OF HUSBAND OR WIFE John I. Dooling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs Mary Mabel ADDRESS 4176 Delmar	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolus			INTERVAL BETWEEN ONSET AND DEATH 10 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Auricular fibrillation DUE TO (c) Arteriosclerotic Heart Disease				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1-25**, 19**49**, to **2-2**, 19**49**, that I last saw the deceased alive on **2-2**, 19**49**, and that death occurred at **9:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE Nathan Kimmelman M.D. (Degree or title)		23b. ADDRESS 2906 Union Blk. St. Louis		23c. DATE SIGNED 2-2-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 5 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
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DATE REC'D BY LOCAL REG. FEB 3 1949		REGISTRAR'S SIGNATURE J. B. Lator		25. FUNERAL DIRECTOR'S SIGNATURE Wm J. Morrell ADDRESS 4212 St. Louis Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Frank J. Pfand

Licensed Embalmer No.

2675

P. O. Address

St. Louis, Mo

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.