

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24742**
5988
Registrar's No.

BIRTH NO. **98553** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY OR TOWN St. Louis, Mo.		a. STATE Missouri	b. COUNTY
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS 3017 Lemp Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MABLE Gertrude Dodier				July 7th, 1949

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 17, 1909	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months Days	IF UNDER 11 HRS. Hours Min
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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) Cuba, Missouri	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME William Davis	13b. MOTHER'S MAIDEN NAME Elizabeth Wilson	14. NAME OF HUSBAND OR WIFE Paul Dodier
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Leona Furness	ADDRESS 1205 Belevue
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic glomerulonephritis		
	II. OTHER SIGNIFICANT CONDITIONS Laennec's Cirrhosis		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5811

22. I hereby certify that I attended the deceased from **6/27/49**, 19___, to **7/7/49**, 19___, that I last saw the deceased alive on **7/7/49**, 19___, and that death occurred at **7:50 AM**, from the causes and on the date stated above.

23a. SIGNATURE Aaron Heudin M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 7/7/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-9-49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUL 8	REGISTRAR'S SIGNATURE J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE Weick Bros.	ADDRESS 2201 So. Grand Bl.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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

William Stelgen

Student Embalmer No.

334

working under my personal supervision.

Student

William Stelgen
Student Embalmer

Signed

Ronald A. Yahrka

Licensed Embalmer No.

3917

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.