

FILED NOV 21 1949 STANDARD CERTIFICATE OF DEATH

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

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH St. Louis. County
a. COUNTY Robert Koch Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Missouri
b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch, Mo
c. LENGTH OF STAY (In this place) 138 days
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital
e. STREET ADDRESS (If rural, give location) 3037a Rutgers

3. NAME OF DECEASED
a. (First) Doris Evelyn Paige
b. (Middle) _____
c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) 11-6-49

5. SEX Fem
6. COLOR OR RACE Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH 7-7-33
9. AGE (In years) (Months) (Days) (Hours) (Min.) 16 4

10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) student
10b. KIND OF BUSINESS OR INDUSTRY student
11. BIRTHPLACE (State or foreign country) Vaughn, Miss
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Hiram Page
13b. MOTHER'S MAIDEN NAME Mollie Clay (Deceased)
14. NAME OF HUSBAND OR WIFE none

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 Record at Robert Koch ADDRESS _____

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, ashenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis
ANTECEDENT CAUSES _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____
DUE TO (b) _____
DUE TO (c) _____

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 _____
20. AUTOPSY? YES NO

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 NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 6-21, 1949, to 11-6, 1949, that I last saw the deceased alive on 11-5, 1949, and that death occurred at 1:00A m., from the causes and on the date stated above.

23a. SIGNATURE Harold E. Russell D.M.D. (Degree or title) _____
23b. ADDRESS Koch Hospital
23c. DATE SIGNED 11-6-49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 11-12-49
24c. NAME OF CEMETERY OR CREMATORY Washington Park Bur.
24d. LOCATION (City, town, or county) (State) Wentz, Walker St Louis

DATE REC'D BY LOCAL REG. 11-9-49
REGISTRAR'S SIGNATURE Herbert St. Wenke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE 3506 Franklin Ave. Missouri ADDRESS _____

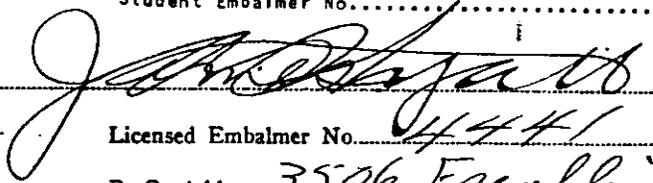
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



Signed.....
Student Embalmer

Licensed Embalmer No. 4441

P. O. Address 3506 Franklin

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.