

FILED MAY 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15034

State File No.

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4464 Registrar's No. 2026

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St Louis	
b. CITY OR TOWN Overland		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8926 Winden		d. STREET ADDRESS (If rural, give location) 8926 Windom	

3. NAME OF DECEASED (Type or Print) a. (First) Gail b. (Middle) Dopking c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) Apr 29 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single /	8. DATE OF BIRTH Oct 3 1946	9. AGE (In years last birthday) 4	10. MONTHS 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City Mo	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Al Dopking	13b. MOTHER'S MAIDEN NAME Heloise Wood	14. NAME OF HUSBAND OR WIFE
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 Al Dopking Overland Mo

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Convulsions		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral damage (type unk) 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 4/30/51	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) 7802
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Herbert P. Lomke (Degree or title) Local Registrar, Vital Statistics	23b. ADDRESS 651 S. Brentwood, Clayton, Mo.	23c. DATE SIGNED 4-30-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/30/51	24c. NAME OF CEMETERY OR CREMATORY Green Kansas
24d. LOCATION (City, town, or county) (State) Kansas	25. FUNERAL DIRECTOR'S SIGNATURE Ortmann Funeral Home 9222 Lakeland Overland Mo	
DATE REC'D BY LOCAL REG. 4/30/51	REGISTRAR'S SIGNATURE Herbert P. Lomke	ADDRESS Ortmann Funeral Home 9222 Lakeland Overland Mo

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Al C Ostmann*.....

Licensed Embalmer No *3478*.....

P. O. Address.....

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.