

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7485  
1632

State File No. 1003  
Registrar's No. 1632

FILED MAR 11 1953

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 1632	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2013	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>7800 Virginia Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Albert K. Dohack</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 10, 1953</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 12, 1889</u>		9. AGE (In years last birthday) <u>63</u>	If UNDER 1 YEAR: Months _____ Days _____	If UNDER 6 Mos. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Frank Dohack</u>			13b. MOTHER'S MAIDEN NAME <u>Rose Unk</u>		14. NAME OF HUSBAND OR WIFE <u>Mathilda</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Roy Dohack 3501a Itaska</u>			
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) <u>Liver Coma from liver failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Scirrhosis of the liver</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hematemesis from ruptured esophageal varices.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u>	
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) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? <u>5810</u>	
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"/>		22. I hereby certify that I attended the deceased from <u>2-26, 1953</u> to <u>2-10, 1953</u> that I last saw the deceased alive on <u>2-9, 1953</u> and that death occurred at <u>330a</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>a. J. Steiner MD</u>			23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>2-11-53</u>		
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>	24b. DATE <u>2-12-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Mausoleum</u>		24d. LOCATION (City, town, or county) (State) <u>Lemay 23, Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Southern Funeral Home 6322 S. Grand St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>FEB 11 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Southern Funeral Home 6322 S. Grand St. Louis, Mo.</u>			

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

Dr. A. J. Steiner  
Mo. Theatre Bldg.  
2 to 4 p.m.

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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

*David Thompson*

Licensed Embalmer No. *4542*

P. O. Address *6322 So. Grove*

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.