

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2457**
Registrar's No. **46**

BIRTH NO. **FILED FEB 8 1954** REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058**

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Charles	
c. LENGTH OF STAY (In this place) life		d. STREET ADDRESS (If rural, give location) 530 Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION 530 Broadway			

3. NAME OF DECEASED (Type or Print)	a. (First) Antwine	b. (Middle) A,	c. (Last) Dorlaque	4. DATE OF DEATH (Month) (Day) (Year) Jan. 29, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 25, 1895	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Days 4	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker	10b. KIND OF BUSINESS OR INDUSTRY General Steel Co.	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Dorlaque	13b. MOTHER'S MAIDEN NAME Alice Aubuchon	14. NAME OF HUSBAND OR WIFE Neoma Lewis
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give way or dates of service) W. W # 1	16. SOCIAL SECURITY NO. 333-03-6948	17. INFORMANT'S SIGNATURE OR NAME Mrs. Neoma Dorlaque, St. Chas., Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Gen. Arterio sclerosis 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Jan 29, 1954**, to **Jan 29, 1954**, that I last saw the deceased alive on **Jan 19, 1954**, and that death occurred at **3:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE A.P. Perich, M.D. (Physician)	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED 1/30/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 1, 1954	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
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DATE REC'D BY LOCAL REG. Jan 30 1954	REGISTRAR'S SIGNATURE H. H. ...	25. FUNERAL DIRECTOR'S SIGNATURE C. Dallmeyer & Son	ADDRESS St. Charles, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 8 19

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 R Amaleng

Licensed Embalmer No. 4832

P. O. Address St. Charles, 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.