

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **25490**BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **531** Registrar's No. **1798**

1. PLACE OF DEATH a. COUNTY St. Louis			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 University City		c. LENGTH OF STAY (in this place) 11 mo	c. CITY OR TOWN University City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 6307 Westminster			e. STREET ADDRESS (If rural, give location) 6307 Westminster					
3. NAME OF DECEASED (Type or Print)	a. (First) JESSIE	b. (Middle) DOBYNE	c. (Last) MAHLER.	4. DATE OF DEATH	(Month) (Day) (Year) July 22, 1954			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 5, 1881	9. AGE (in years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY house wife	11. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME James Bell Dobyne		13b. MOTHER'S MAIDEN NAME Calesta Jane		14. NAME OF HUSBAND OR WIFE Louis Frank Mahler.				
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 ADDRESS Margaret M. Misericocchi, 6307 Westminster					
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
	DUE TO (b) Arteriosclerosis Cerebral					3 yrs		
	DUE TO (c) Diabetes Mellitus					10 yrs		
	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"/>		
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)		260X			
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"/>	21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from 1930 , to 7/22/54 , 19 54 , that I last saw the deceased alive on 7-23 , 19 54 , and that death occurred at 10:30 a.m. , from the causes and on the date stated above.								
23a. SIGNATURE W.H. Oberster, M.D.		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 7/23/54				
24a. BURIAL, CREMATION REMOVAL (Specify)	24b. DATE 7/24/1954	24c. NAME OF CEMETERY OR CREMATORY Valhalla Mausoleum	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri					
DATE REC'D BY LOCAL REG. 7/23/54	REGISTRAR'S SIGNATURE Richard R. Amke, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. Lupton & Sons; 7233 Delmar Blvd.,						

(Licensed Embalmer's Placement on Reverse Side)

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

AUG 16 1954

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.....
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.