

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35309

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9210

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2739 DAKOTA ST.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. STREET ADDRESS 2739 DAKOTA ST.		e. (If rural, give location) 2159	
3. NAME OF DECEASED (Type or Print) a. (First) LILLIAN		b. (Middle)	
c. (Last) DOLL		4. DATE OF DEATH (Month) (Day) (Year) OCT. 11, 1954	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY, 21, 1876
9. AGE (In years last birthday) 78		# MONTHS 1	# YEARS 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MILWAUKEE, WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME UNKNOWN	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE BERNHARDT DOLL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME CLARENCE B. DOLL, 8011 Crestway, STL 23		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive CV Disease  ANTECEDENT CAUSES Morbidity 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 <input type="checkbox"/> NO <input 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)			
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? 443X			
22. I hereby certify that I attended the deceased from 4-15, 1952 to 10-11, 1954, that I last saw the deceased alive on 10-1, 1954, and that death occurred at 1:25 A.M., from the causes and on the date stated above.			
23a. SIGNATURE C. A. Neeter M.D. (Degree or title)		23b. ADDRESS 5600 S. Compton	
23c. DATE SIGNED 10-11-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE OCT. 13, 1954	
24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.	
DATE REC'D BY LOCAL REG. OCT 11 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE WITT BROS. L.V. CO. 2929 S. JEFFERSON		ADDRESS	

E. P. (Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*J. M. Davis*

Licensed Embalmer No.

*3741*

P. O. Address

*2929 So. Jefferson*

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.