

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

State File No. 33418

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <b>8387</b>		
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) <u>1 Mo. 11 Da.</u>		c. CITY OR TOWN <u>St. Louis,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>26 St. Louis Chronic Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>1204 Hickory St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>O.</u> c. (Last) <u>Dofing</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>September 5-1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 22, 1874</u>		
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Worker-Retd.</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Dofing</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Trutt</u>			14. NAME OF HUSBAND OR WIFE <u>Kate Dofing</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>495-26-8567</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Kate Dofing-1204 Hickory Str.</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Bilateral Lower Lobar Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>								
MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Lower Lobar Pneumonia</u>								
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. DUE TO (b) _____ DUE TO (c) _____								
II. OTHER SIGNIFICANT CONDITIONS <u>Anemia due to Peri-arteriolar Nephritis</u> Conditions contributing to the death but not related to the disease or condition causing death <u>5 weeks.</u>								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>446x</u>				20. AUTOPSY? YES <input checked="" 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) (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 <u>July 26, 1957</u> , to <u>Sept. 5, 1957</u> , that I last saw the deceased alive on <u>Sept. 5, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>				23b. ADDRESS <u>5800 Arsenal</u>		23c. DATE SIGNED <u>9/6/57</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 9, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>SEP 7 1957</u> <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser-4228 S. Kingshighway Bl.</u>						

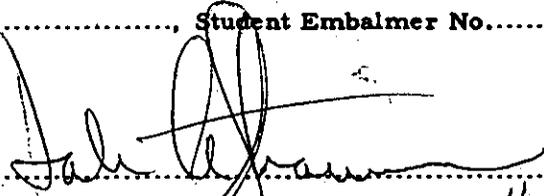
Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed  .....  
Licensed Embalmer No. 4537

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