

pt. Health,  
, & Welfare  
S. Public  
H Service

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v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 25 1957

37355

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

Registar's No. 9667

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Randolph</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Coulterville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b <b>04</b>	d. STREET ADDRESS (If outside, give location) <b>32 518 E. Church St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER PAT DOCKERY</b>			4. DATE OF DEATH Month Day Year <b>OCT. 15, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	9. AGE (In years at birthday) <b>36</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) <b>Coulterville, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>John Dockery</b>		13b. MOTHER'S MAIDEN NAME <b>Pearl Moore</b>	
14. NAME OF HUSBAND OR WIFE <b>Nancy</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Nancy Dockery, Coulterville, Ill.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR HYPERTROPHY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>RHEUMATIC HEART DISEASE (INACTIVE)</b>			<b>20 YEARS</b>
DUE TO (c) _____			<b>416x</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>OCT. 12, 1957</b> to <b>OCT. 15, 1957</b> and last saw her alive on <b>OCT. 15, 1957</b> Death occurred at <b>11:49 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. D. Vermillion, M.D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	
22c. DATE SIGNED <b>10-16-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-16-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>City</b>		23d. LOCATION (City, town, or county) (State) <b>Caledonia, Ill.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 16 '57</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b> 2183			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

