

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014902

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. **2740**

**MAY 1 1959**

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1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA City Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3410 Conneticut</u>	
Length of stay in lb _____		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Doris</u> Middle <u>Ann</u> Last <u>Doebber</u>			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1937</u>		9. AGE (In years last birthday) <u>21</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sears Roebuck Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
13a. FATHER'S NAME <u>Bernard Doebber</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Behrman</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>476-389855</u>		17. INFORMANT <u>Mrs. Leona Doebber 3410 Conneticut</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by Hanging</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>976 X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Her disease progressed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.) <u>While suffering of temporary mental aberration of March 16, 1959</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>3 16 59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>	

21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <u>505 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>1300 Clark</u>
22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul</u>	22d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>E. J. SCHNUR 3125 Lafayette Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 18 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Thomas R. Jewrik* .....

Licensed Embalmer No. *3793* .....

P. O. Address *3125 Lafayette* .....

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.