

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041757

FILED VS NOV 16 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9510**

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS,</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		c. CITY OR TOWN <b>NORTHWOOD</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MISSOURI BAPTIST HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>6619 BARKEN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM G. DOLPHUS</b>		4. DATE OF DEATH Month Day Year <b>OCT, 15, 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEB, 29, 1880-79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLEANER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WABASH R. R.</b>	11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>
13a. FATHER'S NAME <b>JOHN DOLPHUS</b>		14. NAME OF HUSBAND OR WIFE <b>JOHN DOLPHUS 1821 KENTWORTH</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>702-05-0678</b>	
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>Pulmonary embolus</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>420.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Nephrosclerosis</b>		17. INFORMANT Address <b>BRENTWOOD MO.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>5/23/58</b> to <b>10/15/59</b> and last saw him alive on <b>10/14/59</b> . Death occurred at <b>10:00 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Hugo F. Bergman M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	
22c. DATE SIGNED <b>10/16/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/17/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) <b>ST LOUIS MISSOURI</b>	
24. FUNERAL DIRECTOR <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 17 1959</b>	
26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b> <i>mg B.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 M W Rueter

Licensed Embalmer No. 4865  
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.