

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

2

60-003331
764 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. Louis</u> 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>3824 Oregon Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3824 Oregon Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>DORAN</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1960</u>			
--	--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	---	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern Owner</u>	11. BIRTHPLACE (City and state or country) <u>Cincinnati, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>Thomas F. Doran</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Sheridan</u>	14. NAME OF HUSBAND OR WIFE <u>Leon Doran</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.#1</u>	16. SOCIAL SECURITY NO. <u>499-32-6937</u>	17. INFORMANT <u>Leon Doran</u>	Address <u>3824 Oregon Ave.</u>
---	---	------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Inanition and dehydration</u>	<u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinomatosis</u>	<u>4 months</u>
	DUE TO (c) <u>Recurrent Adenocarcinoma of the caecum</u>	<u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>153.D</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 <u>August 1959</u> to <u>January 21, 1960</u> and last saw him alive on <u>Jan. 20, 1960</u>
Death occurred at <u>4:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Keith E. Pipes MD.</u> (Degree or title)	22b. ADDRESS <u>3701 Grandel Square</u>	22c. DATE SIGNED <u>1/21/60</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 25, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) <u>ST. Louis, Co., Mo.</u>
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR <u>Witt Bros. S. & G. 2929 S. Jefferson</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 22 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
---	--	--

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence M. Bill

Licensed Embalmer No. 4375
P. O. Address St. Louis, 23, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.