

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960 917

64-60-004557

INDEXED

Registration District No. 500 Primary Registration District No. 500 Registrar's No. 64 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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>Bellefontaine Neighbors</u>		Length of stay in 1b <u>10 yrs 6 mo 9 days</u>	c. CITY OR TOWN <u>Fredericktown, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State School and Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>302 W. College</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Cynthia</u> Middle <u>Louise</u> Last <u>Dollinger</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1960</u>			
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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>Oct. 15, 1942</u>	9. AGE (last birthday) <u>17 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Fredericktown, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Clarence Dollinger</u>	13b. MOTHER'S MAIDEN NAME <u>Velma Thompson</u>	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT <u>Records of St. Louis State School &amp; Hosp.</u>	Address <u>10695 Bellefontaine Rd.</u>
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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>Broncho-pneumonia, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1-7-60</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Spastic paraplegia</u>	<u>17 yrs.</u>
	DUE TO (c) <u>Microcephalus</u>	<u>17 yrs.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mental Deficiency</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
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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.)
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20c. TIME OF INJURY Hour <u>12:45</u> a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from June 27, 1949 to Jan. 7, '60 and last saw her alive on Jan. 7, 1960  
Death occurred at 12:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph M. Ellersieck M.D.</u>	22b. ADDRESS <u>10695 Bellefontaine Rd.</u>	22c. DATE SIGNED <u>1-7-60.</u>
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23a. BURIAL OR CREMATION <u>Burial</u>	23b. DATE <u>1-9-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Madison Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>Adamson-Webb Funeral Home,</u>	ADDRESS <u>Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-8-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 1

**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

*J. Allen Davis*

Licensed Embalmer No. 403

P. O. Address ph

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.