

**JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED TO NOV 3 1960

**-60-039683**

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **10239** STATE FILE NUMBER

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b <b>38 DAYS</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>VET ADM HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2518 N. JEFFERSON</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>JOSEPH</b> Middle <b>A.</b> Last <b>DOSWALD</b>			Month <b>OCTOBER</b> Day <b>21</b> Year <b>1960</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>5-1-94</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>	
13a. FATHER'S NAME <b>JOSEPH DOSWALD</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA LUNSMAN</b>		14. NAME OF HUSBAND OR WIFE <b>CARRIE DOSWALD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>CARRIE DOSWALD, 2518 N. JEFFERSON,</b>	
16. SOCIAL SECURITY NO.		Address <b>ST. LOUIS, MO.</b>			

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) <b>RESPIRATORY FAILURE</b>		<b>48 HOURS</b>
DUE TO (b) <b>CARCINOMATA OF LUNG</b>		<b>5-7 MONTHS</b>
DUE TO (c) <b>-</b>		<b>-</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH OLD INFARCTION OF POSTERIOR LEFT VENTRICLE &amp; SEPTUM</b>		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 checked="" type="checkbox"/> NO <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 a.m. p.m.		

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 **9-13-60** to **10-21-60** and last saw him alive on **10-21-60**  
Death occurred at **4:15 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>MASASHI KAWASAKI, M.D.</b>	(Degree or title)	22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>10-21-60</b>
---	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/24/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>	23d. LOCATION (City, town, or county) <b>Oakdale, Illinois</b>
---	------------------------------	---	---

24. FUNERAL DIRECTOR <b>CHULICK UND. CO. 1722 S. Jefferson</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
---	--	--

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

*W E Morris*

Licensed Embalmer No. 3360

P. O. Address St Louis

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.