

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026371

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 187

FILED AUG 8 1961

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>St. Charles</u><br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in 1b <u>15-yrs.</u><br>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u><br>c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>d. STREET ADDRESS (If outside, give location) <u>233 Montgomery</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Julius</u> Middle <u>A.</u> Last <u>Dorlaque</u>  |   |  | <b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>29</u> Year <u>1961</u>   |   |  |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>White</u>   | <b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>11-26-1892</u>   | <b>9. AGE (last birthday)</b><br><u>88 yrs.</u>                               | IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HR.  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Retired</u>   |  | <b>11. BIRTHPLACE</b> (City and state or country)<br><u>St. Charles, Mo.</u>  |  |
| <b>12. CITIZEN OF WHAT COUNTRY</b><br><u>U.S.A.</u>   |   | <b>13a. FATHER'S NAME</b><br><u>Antwine Dorlaque</u>   |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>Edna Ford</u>                          |  |
| <b>14. NAME OF HUSBAND OR WIFE</b><br><u>Agnes Gowen Dorlaque</u>   |   | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes Spanish War</u>                          |  |   |  |
| <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>   |   | <b>17. INFORMANT</b> Address<br><u>Mrs. Agnes Dorlaque St. Charles, Mo.</u>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                       |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>10 yr</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Fracture Rt femur</u>   |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | <b>20a. ACCIDENT SUICIDE HOMICIDE</b><br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)<br><u>Fell at home</u>   |  |   |  |
| <b>20c. TIME OF INJURY</b> Hour <u>11:00</u> Minute <u>00</u> Month, Day, Year <u>July 19, 1961</u>   |   |  |  |   |  |
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | <b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE                              |  |
| <b>21. I attended the deceased from</b> <u>5:30</u> to <u>1961</u> and last saw him alive on <u>July 29, 1961</u><br>Death occurred at <u>5:30 p</u> on the date stated above, and to the best of my knowledge from the causes stated.  |   |  |  |   |  |
| <b>22a. SIGNATURE</b> (Degree or title)<br><u>W. H. Roggemeyer MD</u>   |   |  | <b>22b. ADDRESS</b><br><u>St. Charles, Mo</u>  |   | <b>22c. DATE SIGNED</b><br><u>July 1961</u>  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |   | <b>23b. DATE</b><br><u>July 31, 1961</u>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Charles Borromeo</u>   | <b>23d. LOCATION</b> (City, town, or county) STATE<br><u>St. Charles, Mo.</u> |  |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>H.C. Dallmeyer &amp; Sons Co. St. Charles, Mo.</u>  |   |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>10-4-31-61</u>   | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Marcelle Wilson</u>                    |  |

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

AUG 9 1961

**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

*Francis R. Malone*

Licensed Embalmer No.

*4832*

P. O. Address

*St Charles, Mo*

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.