

S. No. 2
-11-10-39
5-17-39
X21492

FILED APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8709**
Registrar's No. **2192**

Registration District No. **791**
Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **2727 Hermitage**
(d) Length of stay: In hospital or institution **nil**
In this community _____

3. (a) PRINT FULL NAME **Georgeanna Doering**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **August Doering** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov. 4, 1854**

8. AGE: Years **85** Months **3** Days **28** If less than one day _____ hr. _____ min.

9. Birthplace **England**

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **William Owen**
13. Birthplace **England**
14. Maiden name **Unknown**
15. Birthplace **England**

16. (a) Informant **Henrietta Bischoff**
(b) Address **2727 Hermitage**

17. (a) **Burial** (b) Date thereof **3-5-1940**
(c) Place: burial or cremation **St. Peters Cem.**

18. (a) Signature of funeral director **Jay B. Smith**
(b) Address **7456 Manchester**

19. (a) **MAR 5 1940** (b) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **2727 Hermitage**
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **2** year **1940** hour **1** minute **25 P.** M.
21. I hereby certify that I attended the deceased from **Mar 1st** to **Mar 2nd**, 19**40**, to **Mar 2nd**, 19**40**, that I last saw her alive on **Mar 2nd**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **to cerebral hemorrhage.**
Due to **arterio-sclerosis**
Due to **senility**
Other conditions _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically. **2 days**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. P. [Signature]** (M. D. or other) _____
Address **3500 Cambridge** Date signed **3/4/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.

.....
working under my personal supervision.

Signed.....

J.P. Burgess

Licensed Embalmer No.

4029

P. O. Address.....

Maplewood

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 this body is not embalmed, above space should be left blank.