

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_

13288  
3490

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1221 S. 6th St 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Willis Doolittle 434

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Rebecca 6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 23, 1857  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 3 24 hr. min.

9. Birthplace Indiana 1  
 (City, town, or county) (State or foreign country)

10. Usual occupation Hotel Owner

11. Industry or business \_\_\_\_\_

12. Name Wm. Doolittle

18. Birthplace Unknown 9  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 7  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature \_\_\_\_\_

(b) Address Ft. Wayne, Indiana

17. (a) Removal (b) Date thereof 4/17/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Albion, Indiana

18. (a) Signature of funeral director C. H. McLaughlin  
 (b) Address 2301 Lafayette Ave

19. (a) Apr 17 1940 (b) \_\_\_\_\_  
 (Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 22  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1221 S. 6th St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
 year 1940 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1930  
 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on April 16, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Chronic Myocarditis 10 yrs

Due to Senility

Other conditions (Include pregnancy within 3 months of death) 9/30

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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? \_\_\_\_\_ (City or town) (County) (State)

(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 \_\_\_\_\_

28. Signature B. A. McLaughlin (M. D. or other) MD  
 Address 6 North 9th St Date signed 4-17-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....

*L.R. Casper*

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

**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.**