

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.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:  
 (a) County Alexian Hosp  
 (b) City or town St. Louis  
 (c) Name of hospital or institution: Alexian Hosp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 In this community 4 days  
 years, months or days

3. (a) PRINT FULL NAME William H. Dornbusch  
 8. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. none

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Anna C. Dornbusch  
 6. (c) Age of husband or wife if alive 64 years  
 7. Birth date of deceased June 13 1871  
 (Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 4  
 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Stationary Engineer

11. Industry or business Cleveland Schools (Retired)

MOTHER FATHER  
 { 12. Name Henry Dornbusch  
 { 18. Birthplace Germany  
 { 14. Maiden name Hahn  
 { 15. Birthplace Germany

16. (a) Informant's own signature Anna C. Dornbusch  
 (b) Address 4225 N Pine

17. (a) \_\_\_\_\_ (b) Date thereof Jan 20 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Bellefontaine Cem

18. (a) Signature of funeral director Chas G Bull  
 (b) Address 4445 Washington

19. (a) \_\_\_\_\_ (b) J. F. Bruch  
 (Date printed local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County St. Louis  
 (c) City or town St. Louis Farmers' Montgomery Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4225 N Pine  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan day 17  
 year 1941 hour 6:05 minute 16 M.  
 21. I hereby certify that I attended the deceased from Jan 16  
 1941 to Jan 17, 1941;  
 that I last saw him alive on Jan 16, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic Failure  
Cirrhosis Portal.  
 Due to Nephritis Interstitial  
 Due to Hypertension

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy above findings

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 A. H. ... (M. D. or other) MD  
 Address 5899 Delmar Date signed 1/17/41

**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.....

*John Ketter*

Licensed Embalmer No..... 3880

P. O. Address.....

**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.**