

FILED DEC 3 1943

1003

9769

Registration District No. 318

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Enroute to City Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4331 North 20th St. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Morris Dollins

3. (b) If veteran, name war None 3. (c) Social Security No. 430-24-1357

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Tennie Dollins 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased May 9, 1912
(Month) (Day) (Year)

8. AGE: Years 31 Months 5 Days 28 If less than one day hr. _____ min.

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

10. Usual occupation Cutter

11. Industry or business _____

MOTHER FATHER

12. Name James A. Dollins

13. Birthplace Unknown Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Ora Lee Johnson

15. Birthplace Mayfield Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Tennie Dollins

(b) Address 4331 North 20th St.

17. (a) Removal (b) Date thereof 11/8/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paragould, Arkansas

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th.
year 1943 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Hemorrhage due to Varicosities (Veins) of Esophagus;

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 11/3
Of autopsy _____

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) (c) Means of injury _____

23. Signature Albert H. Hoppe (M. D. or other) _____
Address _____ Date signed 11/8/43

Duration
Physician
Underline the cause to which death should be charged statistically.

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

6926

6926

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 Gyrosch*.....

Licensed Embalmer No. *3318*.....

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, fact should be so stated above.