

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 31 1945 **318**

Registration District No. _____ Primary Registration District No. **100**

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

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:
Mo. Baptist
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days *P*
(Specify whether years, months or days)

In this community 60 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Theresa Dueringer

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 20 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business At home

MOTHER FATHER

12. Name Nicholis Fuhrmann

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

14. Maiden name Unknown

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

16. (a) Informant Louise Juhlin

(b) Address 7505 Cory Place

17. (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers

18. (a) Signature of funeral director A. W. Meloughlin

(b) Address 230L Lafayette Ave

19. (a) JAN 23 1945 J. F. Brudick
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis *0001*

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. 7528 Cory Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ *n*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20
year 45 hour 9 minute 20 A- M.

21. I hereby certify that I attended the deceased from Jan 12 1945 to Jan 20 1945
that I last saw her alive on Jan 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
myocarditis, chr
arteriosclerosis

Due to arteriosclerosis

Due to senility

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

Major findings:
Of operations 93rd

Of autopsy _____

Duration
4 1/2 days

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 _____

23. Signature J. P. K... (M. D. or other) _____
Address 2345 N. ... Date signed 1/22/45

Ryburn

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. Cooper*.....

Licensed Embalmer No. *3639*.....

P. O. Address *2317 Fayette*.....

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.