

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15009**

FILED MAY 9 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4233**

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town **City St. Louis Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**City Infirmery Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **5/10/34 to 4/26**  
(Specify whether)  
 In this community  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**  
 (c) City or town **City ST. Louis** **1317**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **5800 Arsenal ST.** **9**  
(If rural, give location)  
 (e) Citizen of foreign country? **0** (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME **Denzil A. Douglas**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **unk**  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased **Dec 12 1880**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**66** **4** **14** hr. min.

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

10. Usual occupation **Unknown**

11. Industry or business.....

MOTHER FATHER

12. Name **James A Douglas**  
 13. Birthplace **Arkansas**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Mary Todd**  
 15. Birthplace **Arkansas**  
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmery Records**  
 (b) Address **5800 Arsenal St.**

17. (a) **Removal** (b) Date thereof **4/28/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Little Rock, Arkansas**

18. (a) Signature of funeral director **Albert H. Hoppe**  
 (b) Address **4700 W. Washington Blvd.**

19. (a) **APR 28 1947** (b) **J. F. Budeck**  
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **26**  
 year **47** hour **10** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **5**  
**10** 19 **34** to **4** / **26** 19 **47**  
 that I last saw him alive on **4/26** 19 **47**  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
**Carcinoma of the stomach 27.**  
**with metastasis (46.B)**

Due to **arteriosclerosis gen (9)**

Other conditions  
(Include pregnancy within 3 months of death)

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.....

23. Signature **W. Pappendell Shorrey**  
(M.D. or other)  
 Address **5800 Arsenal** Date signed **4-28-47**

**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 *Henry M. Bramm*

Licensed Embalmer No. *4200*

P. O. Address *St. Louis Mo*

**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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME

Denzil A. Douglas

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced, unknown

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months Days If less than one day hr. min.

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

10. Usual occupation unknown

11. Industry or business

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Brebeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 26  
year 1947 mo. minute M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

**SUPPLEMENTARY**

MOTHER FATHER

15009