

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 19 1947

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9375

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) 2917A Macklind Ave
(If rural, give location)
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME THERESA DUKRINGER

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife George Dueribger
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Dec. 11 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 9 27 hr. min.

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

10. Usual occupation home

11. Industry or business.....

MOTHER FATHER

12. Name Michael Hample
13. Birthplace.....
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothea Coddington
(b) Address 6734 Kenwood Dr.

17. (a) burial (b) Date thereof 10-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd

19. (a) OCT 10 1947 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8th
year 1947 hour 9:50 minute P M.

21. I hereby certify that I attended the deceased from 8-19-47
to 10-8-47
that I last saw her alive on 10-8-47
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix metastases

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations same
Of autopsy same

Duration

PHYSICIAN

Underline the cause of 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. Dalton (M. D. or other) MD
Address 1518 Lafayette Date signed 10-9-47

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

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 Warren A. Carver

Licensed Embalmer No. 3534

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 1102Registration District No. 318Primary Registration District No. 1083Registrar's No. 9370-

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 NAMETheresa Queringer

3. (b) If veteran, name war..... 3. (c) Social Security No. 111-11-1111

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

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

7. Birth date of deceased Dec 11 (Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days 2 (if less than one day) hr. 2 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bredekamp (Registrar's signature) NOT 3 1945

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 Dec Year 1945 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 11 to 11 19.....
 that I last saw her alive on 11 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

S-35676

100-2983