

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6101

State File No. ....  
Registrar's No. **1622**

FILLED MAR. 11 1954

BIRTH NO. 18431-54 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>40 Hrs.</b>	c. CITY OR TOWN <b>Ferguson</b> <b>7109</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <b>Michael</b>	b. (Middle) <b>John</b>	c. (Last) <b>Doherty</b>	<b>Feb. 18, 1954.</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Feb. 17, 1954</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
<b>40</b>		<b>40</b>	<b>40</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>----</b>		13a. FATHER'S NAME <b>Robert Doherty</b>	
13b. MOTHER'S MAIDEN NAME <b>Helen Howlett</b>		14. NAME OF HUSBAND OR WIFE <b>-----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Robert Doherty, Ferguson, Mo.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prematurity - Pulmonary atelectasia -</b> ANTECEDENT CAUSES DUE TO (b) <b>Failure of Respiratory Center</b> DUE TO (c) <b>None</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>7625</b>		22. I hereby certify that I attended the deceased from <b>Feb 17, 1954</b> , to <b>Feb 18, 1954</b> , that I last saw the deceased alive on <b>Feb 18, 1954</b> , and that death occurred at <b>7:10 P. m.</b> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>D. C. N. Lucevian M.D.</b>		23b. ADDRESS <b>4176<sup>th</sup> Shen Ave</b>	
23c. DATE SIGNED <b>2/19/54</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>2/19/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>White Chapel, Ferguson, Mo.</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>FEB 19 1954 J. Carl Smith M.D.</b>		5102 (Licensed Embalmer's Statement on Reverse Side)	

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

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**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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... No Embalming  
*L. G. Shute*  
Licensed Embalmer No. 397

P. O. Address *Terre Haute*

**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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.