FILED SEP 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30426
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2066

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cool Valley — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) HillTop House — Length of stay in lb 8 Mos 2 03
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2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes # No ☐
d. STREET ADDRESS (If outside, give location) 6652 Winona — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print) First ANNA Middle LOUISE Last DOUGHERTY
4. DATE OF DEATH Month 8 Day 16 Year 1957
5. SEX F
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH FEB 27, 1877
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. Operating Rm
10b. KIND OF BUSINESS OR INDUSTRY Barnes Hosp.
11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gottfried Bosse
14. MOTHER'S MAIDEN NAME Anna Hagen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address Mrs Ruth Kaiman, Ferguson, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential Hypertension — years
DUE TO (c)
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO # 2
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug 14, 1957 to Aug 16, 1957 and last saw her/him alive on Aug 15
Death occurred at 10:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Walter J. Kutnyk M.D.
22b. ADDRESS 6000 W. Florissant
22c. DATE SIGNED 8/16/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8-19-57
23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri

24. FUNERAL DIRECTOR ADDRESS WHITE CHAPEL, FERGUSON, MISSOURI
25. DATE RECD. BY LOCAL REG. 8-19-57
26. REGISTRAR'S SIGNATURE Herbert B. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No. .....

working under my personal supervision..

Student .....
Signature of Student Embalmer

Signed Eleanor Province

Licensed Embalmer No. 34

P. O. Address Jenning

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.