

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34869

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2185

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> TOWN <u>Clayton</u>		c. CITY OR TOWN <u>Robertson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp.</u> <u>3 days.</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>Dodson Road</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel - JEWETT - Dorsey</u>		4. DATE OF DEATH Month Day Year <u>9 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1873</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Argiculture</u>	11. BIRTHPLACE (City and state or country) <u>Dorsey Station, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William B. Dorsey</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Cecelia McNally</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Geo. Thomas, 8 Arundel Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>H2O10</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item-18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>8-30-1957</u> to <u>9-1-1957</u> and last saw <u>her</u> alive on <u>9-1-1957</u> Death occurred at <u>8:50 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) <u>Robert H. Blahut</u>		22b. ADDRESS <u>6015 BRENTWOOD BLVD.</u>	
22c. DATE SIGNED <u>9-2-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>9-4-'57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bunker Hill CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>Bunker Hill, Illinois</u>		23e. (State)	
24. FUNERAL DIRECTOR ADDRESS <u>C.R. Lupton &amp; Sons, 7233 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>9-3-57</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert B. Rombe MD</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION  
From family

84.

**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..... *Clarence F. Murray*

Licensed Embalmer No. ....

P. O. Address *St. Louis*

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.