

FILED MAY 12 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016673

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1223

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>UNINCORPORATED 4000</u> <u>9201 WATSON RD.</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. L. Co. HOSP</u>		Length of stay in 1b <u>5 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>9201 WATSON RD</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u></u> Last <u>DOBYNS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1958</u>			
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5. SEX <u>FEMALE</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>Aug. 30, 1907</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTAL CLERK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>post office</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>CHARLES E. HARTSHORN</u>	13b. MOTHER'S MAIDEN NAME <u>NELLIE COFF</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPH E. DOBYNS</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY # <u>49-28-7769</u>	17. INFORMANT <u>MRS. JACQUE MENKE</u>	Address <u>9415 RIDGE AV.</u>
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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>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>4201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>CLAYTON</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
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20d. INJURY OCCURRED WHILE AT <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 <u>CLAYTON</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
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21. I attended the deceased from <u>4-27-58</u> to <u>5-3-58</u> and last saw her/him alive on <u>5-3-1958</u> Death occurred at <u>3:20pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Robert W. Blum</u>	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED <u>5-5-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAY 6, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ</u>	ADDRESS <u>1828 NATURAL BRIDGE</u>	25. DATE RECD. BY LOCAL REG. <u>5-5-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert A. Danke M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 All diseases in Part I must be causally related.

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 *John A. M... ..*

Licensed Embalmer No. *4186*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.