

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=61-011910**

AMENDED  FILED MAR 27 1961 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 767 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Length of stay in 1b <b>16 Mos</b>	c. CITY OR TOWN <b>Manchester</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home Manchester Nursing</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Creve Coeur Ave.</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Doering</b> Last <b>Doering</b>			4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-85</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Joseph Ch.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Co! Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert Schott</b>		13b. MOTHER'S MAIDEN NAME <b>Teresa Bernard</b>		14. NAME OF HUSBAND OR WIFE <b>Alois Doering</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.	17. INFORMANT Address <b>Edward Doering Manchester, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis and Hypertension Do not know</b>	
	DUE TO (c) <b>General Arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____	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 **Nov. 17, 1959** to **March 17, 61** and last saw him alive on **March 17, 61**  
Death occurred at **11:50 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or nurse) <b>Robert W. Laffey M.D.</b>	22b. ADDRESS <b>Box 122, Manchester, Mo.</b>	22c. DATE SIGNED <b>3-20</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>
23d. LOCATION (City, town, or county) <b>Manchester Mo.</b>		23e. (State)
24. FUNERAL DIRECTOR <b>Schrader Funeral Home Ballwin, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-20-61</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

**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 Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Baltimore, Md.

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.