

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3871

-62-016730

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 25 1962

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY _____		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>lifetime</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>9418 Parklind Drive</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Neuman</u> Last <u>Dobbel</u>						4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</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>3-6-1874</u>		9. AGE (last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Port Townsend, Washington</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Andre Neuman</u>				13b. MOTHER'S MAIDEN NAME <u>Mary McQuen</u>				14. NAME OF HUSBAND OR WIFE <u>Charles H. Dobbel (Dec.)</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>						16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Name <u>Charles A. Dobbel</u> Address <u>9418 Parklind Dr.</u>					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>	
										DUE TO (c) <u>420.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Furner of Kidney (not classified)</u>								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 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 checked="" 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>5 am 11/5/58</u> to <u>4/12/62</u> and last saw her/him alive on <u>4/11/62</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Robert Swamer M.D.</u>						22b. ADDRESS <u>1115 Paul Brown Bldg</u>			22c. DATE SIGNED <u>4/12/62</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>4-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>				23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>					
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u>						ADDRESS <u>SAM</u>		25. DATE RECD. BY LOCAL REG. <u>APR 14 1962</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

Dr. Robert G. Warner  
818 Olive  
CH. 14747

1244

**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 Bill C. Branson

Licensed Embalmer No. 4964

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.