

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040152

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9870**

FILED OCT 19 1962

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59
1
8212 67
3
4 0
5 1
6
7 1
8 2
9
10
11
1252-0
13
52
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
DATE AMENDED
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF
MEDICAL CERTIFICATION
DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 15 days	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1033 Osborne Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Kenneth Middle Jerome Last Doerfler, Jr.			4. DATE OF DEATH Month Oct. Day 14 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1929
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ambulance Driver		10b. KIND OF BUSINESS OR INDUSTRY American Ambulance Co.	11. BIRTHPLACE (City and state or country) Springfield, Ill.
13a. FATHER'S NAME Kenneth J. Doerfler		13b. MOTHER'S MAIDEN NAME Cecelia Cummings	14. NAME OF HUSBAND OR WIFE Marilyn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Marilyn Doerfler, Springfield, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO (b) Congenital aortic bicuspid valve with DUE TO (c) insufficiency Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post-op repair of insufficient valve			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 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 9/30/62 to 10/14/62 and last saw her/him alive on 10/14/62 Death occurred at 1:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles L. Rogers M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/14/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-17-62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Ill.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. OCT 15 1962	REGISTRAR'S SIGNATURE Road Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI

1988 Oct 10 J. Douglas T. Kenneth

cardiac catheter

STATEMENT BY LICENSED EMBALMER

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

Robert M. Murray

Licensed Embalmer No.

3749

M.A. U.S.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.