

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034345

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2586 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 9 1963

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 _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH Mo</u>		Length of stay in 1b <u>469 days</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>ROBERT KOCH HOSP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <u>2070 S. SHERMAN ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle <u>J.</u> Last <u>DOLL</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>15</u> Year <u>1963</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6/17</u>	9. AGE (last birthday) <u>46</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>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Christy</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>PHILLIP DOLL deceased</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MABES</u>	14. NAME OF HUSBAND OR WIFE <u>DOLL VIRGINIA NANCE</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>yes WW2</u>	16. SOCIAL SECURITY NO. <u>30 Hospital record</u>	17. INFORMANT <u>Robt Koch Hosp</u>
--	--	--

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 <u>7+ years</u>
IMMEDIATE CAUSE (a) <u>CHRONIC PULMONARY EMPHYSEMA</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 May 3 1962 to Aug 15/63 and last saw him alive on Aug 14/63  
Death occurred at 12 20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank Cohen MD</u>	(Degree or title)	22b. ADDRESS <u>Robt Koch Hosp Koch Mo</u>	22c. DATE SIGNED <u>8/15/63</u>
---	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 19, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR <u>C. Hofmeister Mortuaries</u> ADDRESS <u>7814 So. Broadway St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-15-63</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy</u>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59  
4000  
2 2239  
3  
4. 0  
5. 1  
6  
7. 0  
8. 2  
9527.1  
10  
11  
12. 41-0  
13

DATE AMENDED  
INSTEAD OF  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

41

SEP 10 1963

**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

*Linus E. Hoffmeyer*

Licensed Embalmer No. 3871

P. O. Address 504 W. Ripa

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.