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THE DEPARTMENT OF HEALTH & SENIOR SERVICES OF MISSOURI

STATE OF MISSOURI
CITY OF JEFFERSON } ss

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Missouri Department of Health and Senior Services. Witness my hand as State Registrar of Vital Records and the Seal of the Missouri Department of Health and Senior Services this date of

MAY 15 2020

Kenneth J. Palermo
State Registrar

MO 580-1241 (2-2020) VS-804B

cds

DEPARTMENT OF SOCIAL SERVICES – MISSOURI DIVISION OF HEALTH
(PHYSICIAN, MEDICAL EXAMINER OR CORONER)

CERTIFICATE OF DEATH

124 STATE FILE NUMBER 83 204745

FILED AUG 16 1983

REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____ REGISTRAR'S NO. _____

VS 300 Rev. 1/78

DECEDENT

1. DECEDENT–NAME: FIRST JOSEPH; MIDDLE H.; LAST DORIA
2. SEX: Male
3. DATE OF DEATH (Mo., Day, Yr.): July 29, 1983
4. RACE–(e.g., White, Black, American Indian, etc.) (Specify): White
5a. AGE–Last Birthday (Yrs.): 74
5b. UNDER 1 YEAR: MOS. / DAYS
5c. UNDER 1 DAY: HOURS / MINS.
6. DATE OF BIRTH (Mo., Day, Yr.): Dec. 25, 1908
7a. COUNTY OF DEATH:
7b. CITY, TOWN OR LOCATION OF DEATH: St. Louis
7c. HOSPITAL OR OTHER INSTITUTION–Name (If not in either, give street and number): 3637 Wisconsin
8. STATE OF BIRTH (If not in U.S.A., name country): Mo.
9. CITIZEN OF WHAT COUNTRY: USA
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
11. SURVIVING SPOUSE (If wife, give maiden name):
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ YES ☐ NO
13. SOCIAL SECURITY NUMBER: 494-07-9802
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Man, retired
14b. KIND OF BUSINESS OR INDUSTRY: Auto Repair
15a. RESIDENCE–STATE: Mo.
15b. COUNTY:
15c. CITY, TOWN OR LOCATION AND ZIP CODE: St. Louis 63118
15d. STREET AND NUMBER: 3637 Wisconsin
15e. INSIDE CITY LIMITS (Specify Yes or No): Yes

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS.

PARENTS

16. FATHER–NAME: FIRST Joseph; MIDDLE; LAST Doria
17. MOTHER–MAIDEN NAME: FIRST Hertha; MIDDLE; LAST Schulz
18a. INFORMANT–NAME (Type or Print): Ramon Doria
18b. MAILING ADDRESS: STREET OR R.F.D. NO. 6233 Columbia; CITY OR TOWN St. Louis; STATE Mo.; ZIP 63139

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Removal
DATE: August 2, 1983
19b. CEMETERY OR CREMATORY–NAME: Mount Hope Cemetery
19c. LOCATION: CITY OR TOWN St. Louis; STATE Co. Mo.
20a. FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature): Thomas Kutis; NUMBER 103
20b. NAME OF FACILITY: Kutis Funeral Home Inc
20c. ADDRESS OF FACILITY: 2906 Gravois 63118
21a. REGISTRAR (Signature): William L. Hopely
21b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.): AUG 1 1983

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.
(Signature and Title):
22b. DATE SIGNED (Mo., Day, Yr.):
22c. HOUR OF DEATH: M
22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):

To be Completed by MEDICAL EXAMINER or CORONER Only

23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.
(Signature and Title): Mary E Case MD Dep. Chief Med. Exam.
23b. DATE SIGNED (Mo., Day, Yr.): 8/8/83
23c. HOUR OF DEATH: 4:30 P. M
23d. PRONOUNCED DEAD (Mo., Day, Yr.) ON: 7/29/83
23e. PRONOUNCED DEAD (Hour) AT: 4:30 P. M

24a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print): Mary E. Case, M.D. 1300 Clark, St. Louis, Mo.
24b. MO. LICENSE NO.: 32097
25. IF HOSP. OR INST., Indicate DOA, OP/Emer. Rm., Inpatient (Specify): Scene

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST

PART I

26. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) 63103
(a) Arteriosclerotic Heart Disease — Interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF:
(b) — Interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF:
(c)

PART II OTHER SIGNIFICANT CONDITIONS–Conditions contributing to death but not related to cause given in PART I (a)

27. AUTOPSY (Specify Yes or No): No
28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No): Yes

29a. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify): Natural
29b. DATE OF INJURY (Mo., Day, Yr.):
29c. HOUR OF INJURY: M
29d. DESCRIBE HOW INJURY OCCURRED:
29e. INJURY AT WORK (Specify Yes or No):
29f. PLACE OF INJURY–At home, farm, street, factory, office building, etc. (Specify):
29g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, COUNTY, STATE):
30. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS ☐ YES ☐ NO ☐ UNK