MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 18357

Registered No. 140

1. PLACE OF DEATH
County: St. Louis
Township: Central
City: (No. 8034 Madison Terrace St. Ward)
Registration District No. 789
Primary Registration District No. 60308

2. FULL NAME: Dorothy Lou Donaldson
(a) Residence. No. 8034 Madison Terrace Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 26-1921

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
6	4	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St. Louis
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: James W. Donaldson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Cassiano
(STATE OR COUNTRY): Indiana
12. MAIDEN NAME OF MOTHER: Mayme Washburn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Cashner
(STATE OR COUNTRY): Indiana

14. INFORMANT: Mr. James W. Donaldson
(Address) 8034 Madison Terrace

15. FILED 5/2, 19 28 Nolle B. Gray, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1928, to May 1st, 1928, that I last saw he alive on Apr May 1st, 1928, and that death occurred, on the date stated above, at 8 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia, Persistent
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY): Concussion
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Bacteriological findings
(Signed) A. O. Young, M.D.
5/1/28, 19 (Address) 8136 Page Ave.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oak Grove Cem.
DATE OF BURIAL: 5-3 1928
20. UNDERTAKER: Geo. L. Pleitsch
ADDRESS: 5966 Easton Ave.

N. B.—Name of deceased must be fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

29

1 to 3

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St Louis
Township Carondelet
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 789
Primary Registration District No. 6033 B

File No. .....
Registered No. 140

2. FULL NAME Dorothy Lou Donaldson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED May 2, 1928 Rosella Brace M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1, 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Stomach Poisoning
from food
(duration) — yrs. — mos. — ds.
CONTRIBUTORY (SECONDARY) 3 hrs
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B. — Item of information should be carefully supplied. Every blank should be stated. CAUSE OF DEATH should be stated so that it may be properly classified. Exact statements ... JIANS should state ATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-18357