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

Do not use this space.

8727

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital ..... St. 25 Ward)

File No. ..... Registered No. 2400

16972 **2. FULL NAME** William Donovan

(a) Residence. No. 4x Clark St., 24 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 19 — 1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	63	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 237
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee 2

PARENTS

10. NAME OF FATHER John Donovan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) 15
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Fanny Gillespie
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) 15
(STATE OR COUNTRY) Ireland

14. INFORMANT E. R. Sheridan
(Address) City Hospital

15. FILED FEB 22, 1929 Mary C. Flynn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Feb 22, 1929, that I last saw h. alive on Feb 22, 1929, and that death occurred, on the date stated above, at 2:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage (left)

82.A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 7460 (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? .....

8

Feb 22, 1929 (Signed) Edmund R. Sheridan, M.D.
(Address) City Hospital

*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
St. Peter-Paul	Feb. 23 1929
20. UNDERTAKER	**ADDRESS**
Wacker-Heldens	Feb. 23-29

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Donovan