

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

Do not use this space.

42363

1. PLACE OF DEATH

County.....
Township.....
City *M. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *5351 Delmar*)

File No.....
Registered No. *12088*
St. Ward)

2. FULL NAME

Mary Jane Donnell

(a) Residence. No. *5351 Delmar* St. *12* 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 (*widowed*)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *widow of Samuel D. Donnell*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 18 - 1852*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>77</i>	<i>1</i>	<i>23</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Russellville*
(STATE OR COUNTRY) *Cole Co. Mo.*

10. NAME OF FATHER *Benjamin Henderson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ind.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Sarah Howard*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Russellville*
(STATE OR COUNTRY) *Mo.*

14. INFORMANT *Edw. H. Waller*
(Address) *5351 Delmar Blvd.*

15. FILED *12 1929* *May C Starkoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 11* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 10*, 19 *29*, to *Dec 11*, 19 *29* that I last saw h. *in* alive on *Dec 11 6 05 P*, 19 *29*, and that death occurred, on the date stated above, at *6 05 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

7401 (duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY) *Hypertension* (duration) yrs. *6* mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Phys Ex Only*

(Signed) *Calvin Carver* M. D.

Dec 11 19 29 (Address) *Metropolitan Bldg*

*State the DISEASE CAUSING DEATH, or 2 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

Jefferson City Mo *Dec 12 19 29*

20. UNDERTAKER

ADDRESS

Alexander & Sons 6175 Delmar

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.

