

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

Do not use this space.

14433

**1. PLACE OF DEATH**

County..... Registration District No. *801*  
 Township..... Primary Registration District No. *1103*  
 City *St. Louis* (No. *Mud Humphy Loop*) St. .... Ward .....

File No. ....  
 Registered No. *3777*  
 St. .... Ward .....

**2. FULL NAME**

*John Donaldson*  
 (a) Residence No. *5203 Theodosia Ave.* Ward. *6*  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary Donaldson</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Dec 25 1861</i>		
7. AGE	YEARS <i>68</i>	MONTHS <i>3</i>
	DAYS <i>20</i>	IF LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Chauffeur</i> <i>131</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>137</i> (c) Name of employer		

**5 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 15 1930*  
 17. I HEREBY CERTIFY, That I attended deceased from *Nov 9*, 19*29*, to *4/15*, 19*30*, that I last saw h. *live* on *4/14*, 19*30*, and that death occurred, on the date stated above, at *2.58 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*1 Septicæmia (Staphylococic)*  
*2 Ac Embolic Fever*  
*3 Abscess of Prostate from infection of unknown duration*  
 CONTRIBUTORY (SECONDARY) *Chronic interstitial arterio sclerosis* *nephritis*

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? *Blood Cultures*  
 (Signed) *Geo. J. Mehan* M. D.  
*4/15*, 19*30* (Address) *1006 So Jefferson*

\*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.

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

PARENTS

10. NAME OF FATHER <i>Dont know</i>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <i>Ireland</i> (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER <i>Dont know</i>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <i>Ireland</i> (STATE OR COUNTRY)

14. INFORMANT *Mrs Mary Donaldson*  
 (Address) *5203 Theodosia Ave.*

15. FILED *130* 19*30* *Wm C. Stover* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Cincinnati Ohio* DATE OF BURIAL *April 16 1930*  
 20. UNDERTAKER *Geo. L. Pleitich* ADDRESS *5966 Easton*

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.

1006. Sep. 10. 0.

3. 1. 1.

The name