

JUL 12 1939

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

20365  
Do not use this space.

1. PLACE OF DEATH

(a) County .....  
(b) Township .....  
(c) City St. Louis  
(d) Street No. City Hospital No. 1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

791  
1008

Registered No. 5209

2. PRINT FULL NAME

(a) Residence, No. No Home St. 1 X  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) singl  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 17, 1880  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
59 3 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. nil  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

13. NAME John Mc Donald

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME Elizabeth Slevin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE 6-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) CULLEN-KELLY  
1416 N. TALLOR.

20. FILE JUN 9 1939  
J. F. Beedick  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/3/39, 19  
22. I HEREBY CERTIFY, That I attended deceased from 5/14/39 to 6/3/39, 19...  
I last saw him alive on 6/3/39, 19... Death is said to have occurred on the date stated above, at 12.30 a  
The principal cause of death and related causes of importance were as follows:

Dysenterias (Flapies) Date of onset  
Pellagra  
Other contributory causes of importance:

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? ye

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19...  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify  
(Signed) William Sapsin, M. D.  
(Address) City Hospital No. 1

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

1 X1023

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

*Raymond P. Burke*

*James 3985 (City # 99)* Registered Apprentice No. *3985*, working under my personal supervision.

Signed

*R. P. Campbell*

Licensed Embalmer No.

*3881 (City # 100)*

P.O. Address

*St. Louis, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**