

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10070 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.

Registration District No.

791

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County 1003
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
(Specify whether
In this community 40 yrs
years, months or days)

3. (a) PRINT FULL NAME Isabelle Donaldson 543

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry J. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 28 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 0 29 hr. min.

9. Birthplace Oswego New York
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name John Fenton

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Long

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature I. Donaldson

(b) Address 3550 Pestalozzi St.

17. (a) Burial (b) Date thereof Oct. 30, 29
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director A. Hoffmeister

(b) Address 7814 S. Broadway

19. (a) OCT 30 1939 (b) J. F. Bredes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 116
(d) Street No. 3550 Pestalozzi ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27,
year 1939 hour 6:35 minute P. M.

21. I hereby certify that I attended the deceased from October
18, 1939, to October 27, 1939
that I last saw h. or alive on October 27, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Carditis
Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(e) Means of injury

28. Signature Harold Friedman (M. D. or other)

Address 1515 Lafayette Date signed 10/28/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.