

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.

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37094
 Registrar's No. 1931

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Berkley City
 (c) Name of hospital or institution: St. Louis County Hospital
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Berkley City
 (d) Street No. Pierce & Rosemary Sts.
 (e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME George M. Mc. Donnell 235
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

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

6. (b) Name of husband or wife Lillian Mc. Donnell **6. (c) Age of husband or wife if alive** 43 years

7. Birth date of deceased June 5 1892
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
47	4	28	hr. _____ min.

9. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business

MOTHER FATHER

{	12. Name	<u>Michael Mc. Donnell</u>	
	13. Birthplace	<u>St. Louis</u>	<u>Missouri</u>
{	14. Maiden name	<u>Emma Smiley</u>	
	15. Birthplace	<u>St. Louis</u>	<u>Missouri</u>

16. (a) Informant's own signature Lillian Mc. Donnell
(b) Address Pierce & Rosemary Berkley City

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** 11-4-39
 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
Cullinane Bros.

18. (a) Signature of funeral director _____
(b) Address 1710 N. Grand Blvd.
NOV 2 1939

19. (a) (Date received local registrar) _____ **(b) (Registrar's signature)** [Signature]

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 1 year 1939 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from 10-26-39, 19____, to 11-1-39, 19____; that I last saw him alive on 11-1-39, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Lung abscess **Duration** 6 day

Other conditions _____
 (Include pregnancy within 5 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? _____

23. Signature [Signature] (M. D. or other) _____
Address [Address] **Date signed** 11-2-39

(Licensed Embalmer's Statement on Reverse Side)

114 22

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 Fred Frick

Licensed Embalmer No. 3186

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.

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

Do not use this space.

1. PLACE OF DEATH *St. Louis*
 County *St. Louis* Registration District No. *784*
 Township *Clayton* Primary Registration District No. *200*
 City *Clayton* (No. *St. L. Co. Hosp.*) St. _____ Ward _____

2. FULL NAME *Jos. M. McDonnell*
 (a) Residence, _____ St., _____ 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.

File No. *37097*
 Registered No. *1931*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *M*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
47 4 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____ 19 _____

19. UNDERTAKER (ADDRESS)

20. FILED _____ 19 _____

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 1* 19 *31*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Lung Abscess - ?
cause not known - no autopsy permitted - history not enlightening

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) *H. J. Raymond*, _____ M. D.
 (Address) *St. L. Co. Hosp.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

TEMPORARY

