

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 26360Registration District No. 1884Primary Registration District No. 200Registrar's No. 1412

1. PLACE OF DEATH:

- (a) County ST LOUIS
 (b) City or town Wellston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ST. VINCENT SANITARIUM -
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days 2 3/4

3. (a) PRINT FULL NAME CATHERINE MCDONNELL

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race W. 6. (a) Single, widowed, married, divorced WIDOWED6. (b) Name of husband or wife JOHN J. MCDONNELL 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased FEB 18-1888-
(Month) (Day) (Year)8. AGE: Years 87 Months 5 Days 11 If less than one day _____ hr. _____ min.9. Birthplace NEW PORT ILLINOIS
(City, town, or county) (State or foreign country)10. Usual occupation AT HOME

11. Industry or business _____

12. Name JEREMIAH MAHONEY - 913. Birthplace IRELAND
(City, town, or county) (State or foreign country)14. Maiden name ELLEN O'BRIEN -15. Birthplace UNKNOWN -
(City, town, or county) (State or foreign country)16. (a) Informant's signature ANDREW MCDONNELL(b) Address 48 MOODY W. G. -17. (a) REMOVED (b) Date thereof JULY 29 '40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation KANSAS CITY MO(a) Signature of funeral director M. J. Croghan(b) Address 7146 Maple Easton19. (a) JUL 29 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County St. Louis
 (c) City or town WEBSTER GROVES
 (If outside city or town limits, write "RURAL")
 (d) Street No. 48 MOODY AVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29
year 1940 hour 10 minute 30 A.M.21. I hereby certify that I attended the deceased from August 12, 1938, to July 29, 1940that I last saw her alive on 7/29/1940
and that death occurred on the date and hour stated above.Immediate cause of death arteriosclerotic heart disease

Duration

3 yrsDue to General arteriosclerosis 10 yrDue to Senility with psychosis 2 yrsOther conditions Fracture of hip 7 days
(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? 701While at work? _____ (Specify type of place)
(a) Means of injury _____23. Signature W. B. Jytton (M. D. or other) MDAddress St. Vincent Date signed 7/29/40

1942

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 Francis C. Wilkinson

Licensed Embalmer No. 3565

P. O. Address 7146 Manchester

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
STANDARD CERTIFICATE OF DEATH

State File No. 26360
Registrar's No. 1412-

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Wallerston
(c) Name of hospital or institution: St. Vincent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Catherine M. Donnell

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 29 - year 40
year _____ hour _____ minute _____ M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive or _____ and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

Immediate cause of death Atherosclerotic heart disease
senility & psychosis

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions Fracture of hip 9-24
(Include pregnancy within 3 months of death)

9. Birthplace. (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

18. Major findings:
Of operations 10/24
Of autopsy _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-24-40 (b) _____ (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident, fall
(b) Date of occurrence July 20, 1940
(c) Where did injury occur? St. Louis County, Mo
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Sanitarium
While at work? no (Specify type of place) _____ (c) Means of injury fall

23. Signature W. B. Linton (M. D. or other) _____
Address Dr. Linton Date signed _____

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

SUPPLEMENTARY

