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FILED JUL 7 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22734

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1232

1. PLACE OF DEATH:

(a) County Delaware
(b) City or town Delmar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
EDGEWOOD NURSING HOME #4
(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 Mo. (b) County Delaware
(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 2623 DELMAR BLVD
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years.

3. (a) PRINT FULL NAME MARY PAULINE DONNE

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife BENJAMIN H. DONNE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUG. 20. 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JAMES P. COYLE

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

14. Maiden name CAROLINA GIDLEY

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

16. (a) Informant Benjamin H. Donne

(b) Address 2623 DELMAR BLVD.

17. (a) BURIAL (b) Date thereof JUNE 13. 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director L. M. Mullen

(b) Address 5165 DELMAR BLVD

19. (a) JUN 12 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1940 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from June 1, 1941 to June 10, 1941;
that I last saw her alive on June 10, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 10da

Due to Chr. Nephritis 10yrs

Due to Hypertension 10yrs

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 1318

Of autopsy _____

Duration

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 _____

23. Signature [Signature] M.D. or other _____
Address 340 [Address] Date signed 6-11-41

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

MOTHER FATHER

JAN 28 1947
JAN 28 1947

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.....

John Hetter
.....
Licensed Embalmer No.....

3880

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.