

STANDARD CERTIFICATE OF DEATH

State File No. 16088

FILED JUN 22 1942 791

Registration District No. Primary Registration District No. Registrar's No. 5116

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4157 McPherson  
(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 \_\_\_\_\_

(c) City or town St. Louis 19  
(If outside city or town limits, write "RURAL")

(d) Street No. 4157 McPherson  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Donaldson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1942 hour 7 minute 50 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 1899  
(Month) (Day) (Year)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death:  
Chronic adhesive Pericarditis  
Chronic endocarditis  
(calcified)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace 1 Tenn  
(City, town, or county) (State or foreign country)

Duration \_\_\_\_\_

Underline the cause to which death should be charged statistically.

PHYSICIAN \_\_\_\_\_

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant James J. Brennan

(b) Address 1300 Clark

17. (a) Burial (b) Date thereof 6-7-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Peters Field  
Peep Bros.

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? \_\_\_\_\_

18. (a) Signature of funeral director J. J. Brennan

(b) Address 892 Lafayette

19. (a) HEP: 1 2 1942 (b) J. F. Bladock  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Nature of injury \_\_\_\_\_

23. Signature Walter J. ... (M. D. or other) \_\_\_\_\_

Address ... Date signed 6/10/42

SEP 24 1945

SEP 23 1945

**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.....  
.....  
working under my personal supervision.

Registered Apprentice No. ....  
*Not Embalmed*  
Signed *Frank J. Owens*.....  
Licensed Embalmer No. *2245*.....  
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, fact should be so stated above.