

V. S. No. 2
FORM-2-43
Rev. 5-17-39
X35597

4384

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 63

FILED JAN 19 1944

Registration District No. 317

Primary Registration District No. 6076

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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 Creve Coeur
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Dr. Dennis' office, Olive St Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Victor F. McDonald

3. (b) If veteran, name war WORLD WAR I 3. (c) Social Security No. 498-18-7703

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

6. (b) Name of husband or wife Ida Mae 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased. February 3 1894
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Caretaker

11. Industry or business _____

MOTHER FATHER

12. Name unk

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

14. Maiden name "

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

16. (a) Informant Mrs. Ida Mae McDonald
(b) Address Chesterfield Rd #1

17. (a) Burial (b) Date thereof 1-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Leuis H. Bopp, Inc
(b) Address Kirkwood Mo.

19. (a) JAN 11 1944 (b) E. J. McFarren, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Chesterfield
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Route #1
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8th
year 1944 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from attended for a few minutes only to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Occlusion of the coronary arteries 6:30
Duration _____

Due to Arteriosclerosis and thrombosis

Due to _____

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

Major findings:
Of operations _____
Of autopsy As given above
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 H. A. Greyfoxe, M.D. (M. D. or other)
Address 601 Brentwood Date signed 1/10/44

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..... *Karl W. Spence*

Licensed Embalmer No. *4343*

P. O. Address *7415 George Rd, Me*

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.