

FILED MAR 1945

Registration District No. **318** Primary Registration District No. **1003** State File No. \_\_\_\_\_ Registrar's No. **1738**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **City Hospital**  
(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 **Missouri** (b) County **000 17**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")  
(d) Street No. **912 S. Newstead** (If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Opal L. McDonald**  
(b) If veteran, name war **Nil**  
(c) Social Security No. **Unknown**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Feb.** day **20**  
year **1945** hour **5:30** minute **2** P. M.

4. Sex **Female** 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

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

7. Birth date of deceased: **December 7 1921**  
(Month) (Day) (Year)

Immediate cause of death  
*Subarachnoid & Subdural Hemorrhage from ruptured cerebral artery*  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
**23 2 13** hr. \_\_\_\_\_ min.

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

9. Birthplace **Jadwin Missouri**  
(City, town, or county) (State or foreign country)

Physician  
Underline the cause to which death should be charged statistically.  
**Plc.**

10. Usual occupation **Packing House Worker**  
11. Industry or business \_\_\_\_\_  
12. Name **David McDonald**  
13. Birthplace **Jadwin Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Laura Schafer**  
15. Birthplace **Darien Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Cordelia Medlock**  
(b) Address **4379a Chouteau Ave.**

17. (a) **Burial** (b) Date thereof: **2-23-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salem, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**

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? \_\_\_\_\_

19. (a) **FEB 21 1945** (Date received and registered)  
**J. J. Medlock** (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury **3**  
Signature **Patrick Taylor** (M. D. or other)  
Address **Deputy Coroner** Date signed **2-21-45**

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

**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.....

*W. Wilkins*

Licensed Embalmer No.....

*3575*

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.**