

15060

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED MAY 21 1945

Registration District No.

Primary Registration District No.

1003

4133

318

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: ST MARYS INFIRMARY
(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

3. (a) PRINT FULL NAME Baby Donaldson

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race col 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 May 7 1945
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Clarence Donaldson

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

14. Maiden name Maryett Eyrings

15. Birthplace B'ham Ala
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence Donaldson
(b) Address 1713 Piggott St St Louis Ill

17. (a) burial (b) Date thereof 5/8/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St Louis Ill

18. (a) Signature of funeral director O. G. Cragg
(b) Address 1036 Hudson St St Louis Ill

19. (a) MAY 9 1945 (b) J. T. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St Clair
(c) City or town East St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1713 Piggott ave NR
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1945 hour 2 minute 00 AM.

21. I hereby certify that I attended the deceased from May 7 1945 to May 7 1945
that I last saw him alive on May 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death rematuration
Birth

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 William J. Green (M. D. or other) M.D.
Address 1228 Piggott St St Louis Date signed 5/8/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-1-239 I 19351

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.