

FILED AUG 24 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7227**

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. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days) 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis 1914
(If outside city or town limits, write "RURAL")
(d) Street No. 5048 Bannock
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John R. Donohue

3. (b) If veteran, name war World War #2 3. (c) Social Security No. 497-18-6659

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: July 20 1900
(Month) (Day) (Year)

8. AGE: Years 45 Months 0 Days 25 hr. _____ min. If less than one day

9. Birthplace: St. Louis, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: Bank Clerk

11. Industry or business: First Natl Bank

12. Name: Michael Donohue

13. Birthplace: St. Louis, Mo
(City, town, or county) (State or foreign country)

14. Maiden name: Hellena Foley

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

16. (a) Informant: Miss Della Palmer

(b) Address: 5048 Bannock

17. (a) Burial (b) Date thereof: 8/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Church Burial

18. (a) Signature of funeral director: Joseph Stovall

(b) Address: 1619 St. Bernard

19. (a) AUG 18 1945 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 15 year 1945 hour 8:45 minute 7 P. M.

21. I hereby certify that I attended the deceased from 7-31-1945 to 8-15-1945 that I last saw him alive on 8-15-1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis

Due to: Arteriosclerosis

Due to: Heart Disease

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

Major findings: Of operations: ad

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: 3

23. Signature: Paul H. Kern (M. D. or other) Address: Humboldt Bldg Date signed: 8-17-45

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

MOTHER FATHER

PHYSICIAN Underline the cause to which death should be charged statistically.

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

jos A. Howard

Licensed Embalmer No. 4139

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, fact should be so stated above.