

FILED DEC 8 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. **38460**

Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **2124**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **56 days**
(Specify whether years, months or days)

In this community **Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Webster Groves**
(If outside city or town limits, write "RURAL")

(d) Street No. **736 Eunice**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: MARIE DONOVAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **29th** year **1945** hour **Five** minute **40 P M.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **John Donovan** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **January 1 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **October 4th**, 19**45** to **November 29th**, 19**45** that I last saw her alive on **November 29th**, 19**45** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
66	10	14	hr. _____ min. _____

Immediate cause of death: **Carcinoma of gallbladder metastatic to liver**

Due to _____

Due to **46 f**

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

9. Birthplace **St. Louis County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Phillip Reinhardt

13. Birthplace St. Louis County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Seekamp

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

16. (a) Informant Margaret Creamer - Daughter

(b) Address **6839 Magnolia, St. Louis, Mo.**

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? _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cem**

18. (a) Signature of funeral director [Signature]

(b) Address **7456 Parkersburg ave**

19. (a) 12-9-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place) (c) Means of injury

23. Signature [Signature] (M.D. or other)

Address **601 Brentwood Blvd** Date signed **11-30-45**

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

12 20

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.....

John Ketter

Licensed Embalmer No. 3880

P. O. Address 4355 Washington

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.