

National Office of Vital Statistics
FILED NOV 14 1947

State File No.
Registrar's No. 10158

Registration District No. 318

Primary Registration District No. 1003

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: 3645 Hickory St.
(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 MICHAEL M. DONNELL

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

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife NORA M. DONNELL
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased MARCH 9 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 7 9 hr. min.

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

10. Usual occupation Nil

11. Industry or business.....

12. Name JOHN M. DONNELL

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

14. Maiden name MARGARET SHEEHAN

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

16. (a) Informant Mrs Nora Britt

(b) Address 3645 Hickory St.

17. (a) BURIAL (b) Date thereof NOV 5 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY Cem.

18. (a) Signature of funeral director E. J. Schmur

(b) Address 3125 Lafayette Av

19. (a) NOV 3 1947 (b) J. P. Bradock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3645 Hickory St.
18 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1
year 1947 hour 6 minute 45 - p.m.

21. I hereby certify that I attended the deceased from Oct 15 1947 to Nov 1 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Chronic Myocarditis

Due to Arterio Sclerosis

Due to.....

Other conditions (include pregnancy within 3 months of death) 93

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.....
(Specify type of place)
Where at work..... (e) Means of injury.....

23. Signature J. P. Bradock (M. D. or other).....
Address 1537 So. Broad Date Nov 3 1947

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING 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.....

Jose B. Hollman

Licensed Embalmer No.....

4014

P. O. Address.....

3125 Lafayette Ave

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.