FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 30 1948

Registration District No. 42

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 25489

Registrar's No. 901

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Years (Specify whether
In this community 8 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. St. Joseph Hospital 10 & Powell
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sister- Josephine Donnell

3. (b) If veteran, name war None

3. (c) Social Security No. None

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

7. Birth date of deceased Unknown (Month) (Day) 1875 (Year)

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Religious Work

11. Industry or business St. Joseph Hospital

FATHER
12. Name Michael S.C.Donnell
13. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine E. McCabe
15. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Catherine (Spurior)

(b) Address St. Joseph Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.25-48 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. Sidenfaden

(b) Address 1802 Union Str. St. Joseph Mo.

19. (a) 8-27-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 3820

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1948 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from Dec 23, 1947, to Aug 23, 1948;
that I last saw her alive on Aug 23, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Dead Mel.	4 yrs
Due to	
Due to	
Other conditions Par agitans (Include pregnancy within 3 months of death)	3 yrs

Major findings:
Of operations
Of autopsy

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

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)

While at work? (e) Means of injury

23. Signature Frank Hardigan (M. D. or other)

Address 620 Francis Date signed 8/24/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....Robert L Gayle

Licensed Embalmer No.....3308

P. O. Address.....St Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.