

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6111**
1151
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 3636 Bowan	
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Pete b. (Middle) c. (Last) Donovan			4. DATE OF DEATH (Month) (Day) (Year) Feb 4 1949		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	
8. DATE OF BIRTH July 6, 1880		9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Pete Donovan		13b. MOTHER'S MAIDEN NAME Emma Wilter	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 494-05-4498	
17. INFORMANT'S SIGNATURE OR NAME Josephine Eistrup		ADDRESS 3636 Bowan			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 424X				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:00 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Josephine Eistrup		23b. ADDRESS 1300 Black		23c. DATE SIGNED 2/7/49	
24a. BURIAL (CREMATION) REMOVAL (Specify) Burial		24b. DATE 2/8/49		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
24d. LOCATION (City, town, or county) (State) St Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons		ADDRESS 7027 Gravoie	
DATE REC'D BY LOCAL REG. FEB 7 1949		REGISTRAR'S SIGNATURE J. B. Lusater			

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravois*

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.