

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 35071

8905

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis</i>		c. LENGTH OF STAY (In this place) <i>7 days</i>	c. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis</i>		17
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Missouri Baptist Hosp.</i>			d. STREET ADDRESS (If rural, give location) <i>3829 Kennerly</i>		
3. NAME OF DECEASED (Type or Print) a. (First) <i>Charles</i>		b. (Middle) <i>Donnelly</i>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <i>10-14-49</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>July 4, 1893</i>	9. AGE (In years last birthday) <i>66</i>	10. IF UNDER 1 YEAR <i>3</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>shipping clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Rice Box</i>	11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <i>John Donnelly</i>		13b. MOTHER'S MAIDEN NAME <i>Doris Know</i>		14. NAME OF HUSBAND OR WIFE <i>Mary</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>077-03-7899</i>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Mrs. Mary Donnelly, 3829 Kennerly</i>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocardial infarction</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary occlusion</i> DUE TO (c) <i>Arteriosclerosis</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>8 days</i> <i>uncertain</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <i>St. Louis Mo.</i>	21f. HOW DID INJURY OCCUR? <i>420!</i>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
22. I hereby certify that I attended the deceased from <i>Oct 6, 1949</i> to <i>Oct 14, 1949</i> , that I last saw the deceased alive on <i>Oct 14, 1949</i> , and that death occurred at <i>10<sup>00</sup> P.m.</i> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>Wm. C. Macdonald M.D.</i>		23b. ADDRESS <i>539 N. Grand Ave.</i>		23c. DATE SIGNED <i>10-16-49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Oct. 18, 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>		
DATE REC'D BY LOCAL REG. <i>OCT 17 1949</i>	REGISTRAR'S SIGNATURE <i>J. B. Frazier</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Gr. A. Howard 1619 So. Grand</i>		

WRITE PLAINLY—USING UNEADING 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

*Elmer D. Paulwell*

Licensed Embalmer No. 4077

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.