

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10377
2405
Registrar's No.

318

1003

509

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

| | | | | | | | | | |
|---|------------------------|---|--|--|--|---|--------------------------------|---|--|
| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | State File No. 10377 2405 | | | |
| 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. LENGTH OF STAY (in this place) 12 Days | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 2069 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital | | | | f. STREET ADDRESS (If rural, give location) 5339 Northland Ave. | | | | | |
| 3. NAME OF DECEASED (Type or Print) Michael | | a. (First) | | b. (Middle) J. | | c. (Last) McDonald | | 4. DATE OF DEATH (Month) (Day) (Year) Mar 12, 1951 | |
| 5. SEX M. 0 | 6. COLOR OR RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH Oct. 26, 1868 | | 9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months Days | IF UNDER 100 HRS. Hours Mins. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Carpenter | | 11. BIRTHPLACE (State or foreign country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13a. FATHER'S NAME McDonald | | | 13b. MOTHER'S MAIDEN NAME Ann Leonard | | | 14. NAME OF HUSBAND OR WIFE Anne McDonald | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME Margaret McDonald 5339 Northland Ave | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pneumonia</i> | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | 5 days | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Fracture of lt. hip</i> | | | | | | 11 days | |
| 19a. DATE OF OPERATION 3-1-51 | | 19b. MAJOR FINDINGS OF OPERATION <i>Interochanteric fracture of lt. hip</i> | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE <i>Accident</i> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i> | | 21c. (CITY, TOWN, OR TOWNSHIP) <i>St. Louis</i> | | 000 (COUNTY) | | (STATE) <i>Mo.</i> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Mar. 1 1951 2P</i> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <i>Fell at home</i> | | E9030 | | | |
| 22. I hereby certify that I attended the deceased from <i>Mar. 1</i> , 1951, to <i>Mar. 12</i> , 1951, that I last saw the deceased alive on <i>Mar 12</i> , 1951, and that death occurred at <i>11.25P</i> on the date stated above. <i>21</i> | | | | | | | | | |
| 23a. SIGNATURE <i>Dr. W. J. Stuever</i> | | | | (Degree or title) 0 | | 23b. ADDRESS <i>3720 Washington</i> | | 23c. DATE SIGNED <i>3-13-51</i> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24b. DATE <i>3-15-51</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 REGISTRAR'S SIGNATURE <i>MAR 1 4 1951 J. B. Laster</i> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly 3840 Lindell Blvd</i> | | | | | |



2825

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

W. VanMatre

Signed.....

Student Embalmer

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.