

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43608

FILED JAN 10 1953

State File No. _____

Registrar's No. 11307

BIRTH NO. _____		REG. DIST. NO. - 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11307			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Ill.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warsaw</u> <u>etern St.</u> <u>8120</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1335 Webster St.</u> <u>8</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) _____ c. (Last) <u>McDonnell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 8 1952</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 29 1884</u>		9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 2 HRS. Hour _____	Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Warsaw Ill</u>		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <u>Dennis McDonnell</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Morrison</u>			14. NAME OF HUSBAND OR WIFE <u>Emma McDonnell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sister Bertha DePaul Hospital</u>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease.</u> 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 _____				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) _____					
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"/>		21f. HOW DID INJURY OCCUR? <u>4.2002</u>					
22. I hereby certify that I attended the deceased from <u>Dec 3</u> 19 <u>52</u> , to <u>Dec 8</u> 19 <u>52</u> , that I last saw the deceased alive on <u>Dec 8</u> 19 <u>52</u> , and that death occurred at <u>6:41</u> a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Deceased or title) <u>Robert Patasinski, M.D.</u>				23b. ADDRESS <u>508 N. Grand Blvd.</u>		23c. DATE SIGNED <u>12/8/52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 12 1952</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Kahoka Mo.</u>			
DATE REC'D BY LOCAL REG. <u>DEC 8 1952</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sullivan's 2849 N. Euclid Ave.</u>				

(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.....

.....
working under my personal supervision.

Student
Student Embalmer

Signed *Robert L. Pinkman*
Student Embalmer No.
Licensed Embalmer No. 3553

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.