

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26657

State File No. _____
Registrar's No. **6218**

FILED JUL 31 1953

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 Missouri		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 2 days		STREET ADDRESS (If rural, give location) 6733 Vermont ave.		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		3. NAME OF DECEASED a. (First) EDWARD		b. (Middle) B.	
c. (Last) MC DONALD		4. DATE OF DEATH 6-18-53		5. SEX male	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) married		8. DATE OF BIRTH 5-18-1891	
9. AGE (In years last birthday) 62		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store helper		10b. KIND OF BUSINESS OR INDUSTRY Civil service	
11. BIRTHPLACE (City and State or Foreign Country) Pickneyville, Ill.		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME James C. McDonald	
13b. MOTHER'S MAIDEN NAME Margaret Jones		14. NAME OF HUSBAND OR WIFE Margaret 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. u nknown		17. INFORMANT'S SIGNATURE OR NAME Margaret McDonald, 6733 vermon		ADDRESS	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6-16-53	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from 1945 , to 6/18 , 1953 that I last saw the deceased alive on 6-18 , 1953 and that death occurred at 10:45 m., from the causes and on the date stated above.					
23a. SIGNATURE W. Eades M.D.		23b. ADDRESS 7602 S Budy		23c. DATE SIGNED 6/19/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-19-53		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Pickneyville, Ill.		DATE REC'D BY LOCAL REG. JUN 22 1953		REGISTRAR'S SIGNATURE Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE Pyatt F.H.,		ADDRESS Bickneyville, Ill.			

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.....
Signature of Student Embalmer

Signed *Bu Elhazzman*.....

Licensed Embalmer No. *4366*.....

P. O. Address *St. Louis, Mo.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.