

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30204

FILED AUG-31-1953

State File No.

318

1003

7858

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>2079</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>5028 Tucker Ave.</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Paul</u>				d. STREET ADDRESS				
3. NAME OF DECEASED (Type or Print) <u>ELLA MEDONOUGH</u>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 10, 1953</u>			5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Mar 3, 1891</u>			9. AGE (in years, last birthday) <u>61</u>		10. USUAL OCCUPATION (Kind of work done during most of working life, if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>			12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>James Dougherty</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Pellon</u>	
14. NAME OF HUSBAND OR WIFE <u>Michael W. Donough</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Michael W. Donough</u>	
18. ADDRESS <u>5028 Tucker</u>			19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19c. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>				
*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.				
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) <u>H20.1</u>		
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 <u>Aug 7, 1953</u> , to <u>Aug 10, 1953</u> , that I last saw the deceased alive on <u>Aug 9, 1953</u> , and that death occurred at <u>5 a. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>J. J. Quinn M.D.</u>				23b. ADDRESS <u>539 N. Grand St. St. Louis</u>		23c. DATE SIGNED <u>8/11/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 13, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>AUG 11 1953</u>		REGISTRAR'S SIGNATURE <u>J. J. Quinn</u>		25. JUNIOR DIRECTOR'S SIGNATURE (Address) <u>J. J. Quinn, 1389 Union</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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald Yashinski

Licensed Embalmer No.

3917

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.