

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

43292

State File No. _____

BIRTH NO. FILED JAN 8 1954 REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 498

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Independence		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence	
c. LENGTH OF STAY (in this place) 40 yrs		d. STREET ADDRESS (If rural, give location) 601 N. Main St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence, 601 N. Main St.		70050	

3. NAME OF DECEASED (Type or Print) a. (First) Marie	b. (Middle) Elsa	c. (Last) McDonald	4. DATE OF DEATH (Month) (Day) (Year) Dec. 30, 1953
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH FEB. 3, 1890	9. AGE (In years last birthday) 63	If UNDER 1 YEAR Months	If UNDER 1 YEAR Days	If UNDER 18 HRS. Hours	If UNDER 18 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (City and State or Foreign Country) Metz, Germany	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE John G. McDonald (deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME John D. McDonald	ADDRESS Kansas City, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia due to Uremic Coma		12-29-53
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage		12-5-53
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12-5, 1953, to 12-30, 1953, that I last saw the deceased alive on 12-29, 1953, and that death occurred at 3:15P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. J. J. Fennar, D.O.	23b. ADDRESS Indep. Mo.	23c. DATE SIGNED 12/31/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/2/54	24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	24d. LOCATION (City, town, or county) (State) Independence, Mo.
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DATE REC'D BY LOCAL REG. 1-1-54	REGISTRAR'S SIGNATURE [Signature]	354 F. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Independence, Mo.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

JUN 13 1955

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 Richard R. Francis

Licensed Embalmer No. 4863

P. O. Address Indep. 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 this body is not embalmed, fact should be so stated above.